

FOR STATE HEALTH DEPT.

Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03259

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <i>Richard</i>		First Middle Last <i>H. ANDRES</i>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>10</i> Year <i>1969</i>		2b. HOUR <i>P</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2/25/19</i>	6. AGE (In years last birthday) <i>50</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>10</i> Year <i>1969</i>	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co</i>	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North ARUNDEL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec. Co</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Richard H. P. Andres</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Hattie Myer</i>		13e. STREET AND NUMBER <i>324 New Jersey Avenue</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>WW 2 215-09-5354</i>		17. INFORMANT ADDRESS <i>Mrs. Alice W. Andres, same as 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mtrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>3/10/69</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>13 March 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie, AA Co., Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Kirkley Funeral Home, Glen Burnie, Md. 21061</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

08580

MAR 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03260		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03255		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR
MARK			E		ANTHONY	MARCH 14 1969		8P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
MALE		CAUCASIAN		OCT 1 1884		84 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		USA				ANNE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE		NORTH ARUNDEL CONVALESCENT CENTER						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND				BALTIMORE				BALTIMORE 1637 JOPLIN ST. 21224
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
			?	?	ANTHONY	DONT KNOW		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO		218-22-0500		MRS MAPELINE MEREDITH 3018 DUNLEER RD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u>								<u>sudden</u>
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) <u>M. I. E. 6-11</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/69</u> , 19 <u>69</u> , to <u>3/14/69</u> , that (I) (we) last saw the deceased alive on <u>3/14/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John E. Stern, MD</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/14/69</u>
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		3/17/69		MEADOW RIDGE		DORSEY MD		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
ULLRICH FUNERAL HOME - PUNDALN MD.						DATE 19-1969		

03560

CHRONICLE OF DEATH

03560

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06268

1. DECEASED-NAME (Type or print) <i>John</i> <i>Armitage</i>			2a. DATE OF DEATH Month <i>MAR</i> Day <i>14</i> Year <i>1969</i>		2b. HOUR <i>8:45</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>6-18-90</i>		6. AGE (In years lost birthday) <i>78</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. COUNTY OF DEATH <i>A A</i>			9. COUNTY OF DEATH <i>A A</i>		
10. CITY OR TOWN OF DEATH <i>Reverell Highway, Pikesville, Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bay Manor</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>A A</i>	
13c. CITY OR TOWN <i>Bristol</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Edward Phipps</i> Address <i>Bristol Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>185X</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer prostate @ metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Emily H. Wilson</i> M.D. DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>Emily H. Wilson</i>				22e. ADDRESS <i>Lothian, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-17-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>	
23d. LOCATION (City or Town) (County) (State) <i>Friendship A A Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>Bernard Handosky</i>		ADDRESS <i>Lidlesville Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

185X
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WILLIAM WILSON

Friendship, and
the United States of America

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03261

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03256

Item 23 Film 412 4/30/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Lizzie Dora Baker</i>			2a. DATE OF DEATH Month Day Year <i>Mar. 28 1969</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>cauc.</i>	5. DATE OF BIRTH <i>Aug. 3, 1880</i>		6. AGE (In years last birthday) <i>88</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Anne Arundel</i> Md.		
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Annapolis Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Box 382 College Pa.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>Dade</i> ✓	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>- - -</i>	
14. FATHER'S NAME First Middle Last <i>F.N. UNKNOWN Morris</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Russell W. Adamitz</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4123</i> IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>15 YEARS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CEREBRAL ARTERIOSCLEROSIS</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from <i>OCT</i> , 1965, to <i>3-28</i> , 1969, that (b) (we) last saw the deceased alive on <i>3-28</i> , 1968, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edward S. Bedem</i>		22c. DATE SIGNED <i>3-28-69</i>		22d. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>3/31/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grace Land Memorial</i>	
23d. LOCATION (City or Town) (County) (State) <i>Coral Gables Dade Fla.</i>		24. FUNERAL DIRECTOR <i>Bendly E. Hopping</i>		25a. REC'D BY REGISTRAR DATE <i>APR 1 1969</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Hopping Funeral Home - Annapolis, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

08850

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

08850

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]



03262

CERTIFICATE OF DEATH

03257

1. DECEASED-NAME (Type or print) William Norman Baldwin			2a. DATE OF DEATH Month March Day 27 Year 1969			2b. HOUR P. 3:05 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 1, 1886		6. AGE (In years last birthday) 82		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) A.A. Co. Govt.		12b. KIND OF BUSINESS OR INDUSTRY RET			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e. STREET AND NUMBER 29 Franklin St.			
14. FATHER'S NAME First Middle Last William H. Baldwin			15. MOTHER'S MAIDEN NAME First Middle Last Iva Lyles						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. =		17. INFORMANT BERTRICE S. Baldwin		Address #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral myocardial infarction**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from July , 19 62 , to March , 19 69 , that (1) (we) last saw the deceased alive on 3/26 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John L. Hedeman		DEGREE John L. Hedeman, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/28/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1407 Forest Drive, Annapolis, Md.					

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-29-69		23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial		23d. LOCATION (City or Town) (County) (State) Milfersville A.A. Md.	
24. FUNERAL DIRECTOR John M. L. Lyles Annapolis, Md.				25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03263

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03258

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
DANIEL L BARNHART						3 9 1969				12 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
M	W	3-30-18	50 YRS.					3 9 1969		12 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Penna.		U. S. A.				Anne Arundel Co					
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie			DOR-NORTH PROVIDE L			Truck Driver			Robinson Oil Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Anne Arundel			Glen Burnie		YES <input type="checkbox"/> NO <input type="checkbox"/>		1601 Heathwood Rd. 21061	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Moss D. Barnhart						Virginia Stewart					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			217-12-1597			Catherine W. Barnhart			Glen Burnie, Md. 1601 Heathwood Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac disease</u> 4299 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Shunt</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		E. L. Barnhart						3-9-69			
								ADDRESS (Street, city, town, or county)		N.A. Co.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3-12-69		Meadowridge Cemetery		Dorsey Rd.,		Howard		Md.	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard				4107 Wilkens Ave. 21229				MAR 12 1969			

92520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

03264										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03259									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Lee D. Barron										3 Month 10 Day 69 Year										7:05A									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Male			white			4-16-06			62 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Penna.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Glen Burnie			North Arundel			Realtor			Self Emp.																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Md.			Anne Arundel			Glen Burnie						304 Central Ave. N.W.																	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Frank F. Barron					Mary J. Phillipi																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
Unknown					223 09 3610					Mrs. Beatrice Barron (wife) Same As #13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>																													
DUE TO, OR AS A CONSEQUENCE OF <u>ASHD e acute sclerous</u>																													
(b) <u>Azotemia</u>																													
DUE TO, OR AS A CONSEQUENCE OF <u>above</u>																													
(c) <u>Occult malignancy and/or embolism</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED																			
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21b. TIME OF INJURY HOUR A.M. Month Day Year 19																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21f. LOCATION Street or R.F.D. No. City or Town County State																			
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)																													
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5, 1969</u> , to <u>3/10, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>B. A. de Guzman, M.D.</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>3/10/69</u>																			
22d. PHYSICIAN'S NAME (Type) <u>B. A. de GUZMAN</u>										22e. ADDRESS <u>335 HOSPITAL DR. GLEN BURNIE, MD. 21061</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE																			
Burial										March 13, 1969																			
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Glen Haven Memorial Park										Glen Burnie, Maryland																			
24. FUNERAL DIRECTOR <u>R. J. Singleton</u> ADDRESS <u>Singleton Funeral Home</u>										25a. REC'D BY REGISTRAR																			
Glen Burnie, Maryland										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																			
DATE <u>MAR 12 1969</u>																													

52550

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

03265		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03260	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
George			T.	Beckmann	Month Day Year		
3. SEX			4. RACE		5. DATE OF BIRTH		
male			white		16 July 1893		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
A. A. Co.			U.S.		9. COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
A. A. Co.			1113 Armistead St.		Balto-Tenns.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. STREET AND NUMBER		
md.			A. A. Co.		1113 Armistead St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
T			Beckmann	Rose	(Gutierrez)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
no			218-10-5909A		Edna M. Beckman (WIFE)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular disease</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
		HOUR A.M. Month Day Year					
		P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		
					Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 19 67</u> , to <u>March 19, 19 69</u> , that (I) (we) saw the deceased alive on <u>March 19, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE						22c. DATE SIGNED	
Morton M. Krieger M.D.						March 19, 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
Morton M. Krieger, M.D.						615 Hammonds Lane	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3/22/69		Mendham Memorial PK.		Howard Co. Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert Wong		DATE		MAR 20 1969		Charles Judge	
Singleton Funeral Home		Balto-Tenns.					

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CENTRAL STATE OF DEATH

U.S. 20

George T. Beckmann
Male
White
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A.A.C. Beantown
Beantown
Beantown (wife)
Beantown (wife)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03266

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03261

1. DECEASED-NAME (Type or print) Mary Agnes Benack			2a. DATE OF DEATH Month March Day 1 Year 1969			2b. HOUR M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 19 February 1911		6. AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 310 Fourth Ave. S. W.		
14. FATHER'S NAME First Rogan Middle Last 			15. MOTHER'S MAIDEN NAME First Helen Middle Lavin Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 055-09-0896		17. INFORMANT Address Warren H. Benack, same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 3969 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-22, 1965 , to 2/17, 1969 , that (I) (we) lost saw the deceased alive on 2/17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Andrew R. Sosnowski M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3 March 69			
22d. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski, M. D.						22e. ADDRESS 4016 Ritchie Hwy., Baltimore, Md.		22f. ADDRESS 21225			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4 March 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) Glen Burnie, AA, Md.					
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md. 21061				ADDRESS		25a. REC'D BY REGISTRAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CHARTER OF RIGHTS

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Phillip</i> First Middle Last <i>Blake</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>21</i> Year <i>1969</i>			2b. HOUR <i>11 A.M.</i>				
3. SEX <i>male</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH <i>5/20/1905</i>		6. AGE (In years last birthday) <i>63</i> YRS.		7c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>21</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>				
10. CITY OR TOWN OF DEATH <i>Davidsonville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>—</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>A.H.</i>			13c. CITY OR TOWN <i>Davidsonville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <i>Charles</i> First Middle Last <i>Blake</i>			15. MOTHER'S MAIDEN NAME <i>Rachel</i> First Middle Last <i>Brown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-60-1768</i>			17. INFORMANT <i>Minnie E. Blake</i>			ADDRESS <i>Davidsonville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Diabetes Mellitus</i> (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF <i>—</i> (c) <i>—</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>years</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <i>—</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>—</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <i>—</i>			21b. TIME OF INJURY Month, Day, Year <i>—</i> HOUR A.M. <i>—</i> P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>No injury</i>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i>			21f. LOCATION Street or R.F.D. No. <i>—</i> City or Town <i>—</i> County <i>—</i> State <i>—</i>				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <i>Charles H. Wirth</i>			EXAMINER'S NAME (Type) <i>Charles H. Wirth, MD</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>3/21/69</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>3-25-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Crownwood</i>			23d. LOCATION (City or Town) (County) (State) <i>Owensville Md.</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>			ADDRESS <i>—</i>			25a. REC'D BY REGISTRAR <i>—</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	
						DATE <i>MAR 24 1969</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03268		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03263				
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR		
Baby Blunt				March 20 1969				5:45		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Negro		March 19, 1969		YRS.		MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen. Hospit al			Newborn				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Churchton					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
John Waters				Ann Lyda Blunt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No						Marie Blunt Churchton Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries										
7663 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transverse lie.										
(c) Prematurity										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 3/19, 1969, to 3/19, 1969, that (I) (we) last saw the deceased alive on 3/19/69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
Antonio M. Rivera, M.D.						22e. ADDRESS		South Riv Med Cent., Edgewater, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial 3-23-69			3-23-69		Franklin		Seale Md			
24. FUNERAL DIRECTOR						25a. REGD. BY		25b. REGD. TRANS. SIGNATURE		
William Bessett						MAR 24 1969		[Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

03269										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03264																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
JOHN										March 19 1969										0215																																							
3. SEX Male										4. RACE Caucasion										5. DATE OF BIRTH 23 April 1896										6. AGE (In years last birthday) 72 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Hungary										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Anne Arundel Md.																													
10. CITY OR TOWN OF DEATH Ft. Meade										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7832 Harris Loop, Md.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Doctor										12b. KIND OF BUSINESS OR INDUSTRY Research																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Anne Arundel										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 7832 Harris Loop																													
14. FATHER'S NAME John										15. MOTHER'S MAIDEN NAME Maria Babos																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO. 342-26-9373										17. INFORMANT John Bokor, son										Address 7832 Harris Loop, Ft. M.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH aprox. 30 min																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (X) (this hospital) attended the deceased from <u>19 Mar</u> , 19 <u>69</u> , to <u>19 Mar</u> , 19 <u>69</u> , that (we) (we) lost the deceased above on <u>DOA</u> <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE James Warde Mayne										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 19 Mar 69																																							
22d. PHYSICIAN'S NAME (Type) JAMES WARDE, MAJ, MC										22e. ADDRESS Kimbrough Army Hosp.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 3/22/69										23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery										23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.																													
24. DECEASED BY HOPPING FUNERAL HOME - Annapolis, Md.										25a. REC'D BY REGISTRAR MAR 24 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03270

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) PATRICIA M BOYD			2a. DATE OF DEATH 3 Month 25 Day 69 Year			2b. HOUR 11:20			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/19/67		6. AGE (In years last birthday) 2 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? A.A. 28a		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1215 Gilford Road	
14. FATHER'S NAME First Middle Last Kenneth A Boyd			15. MOTHER'S MAIDEN NAME First Middle Last Patricia M. Manning						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Chart: North Arundel Glen Burnie					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 0799 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Colostomy (meconatal enterocolitis) - 2 days of age									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/19, 1967 , to 3/25, 1967 , that (I) (we) last saw the deceased alive on Sept 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alvin M. Hecker DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) DR. ALVIN HECKER				22e. ADDRESS 310 Crain Highway, SW, Glen Burnie, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 28 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, AA Co., Md.			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR MAR 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

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03271 Film G411 4/2/69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03266	
Items #14&15, Film G410 3/24/69 km										CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last Helena Lacy Brooks			2a. DATE OF DEATH Month 3 Day 17 Year 69			2b. HOUR 1:40pM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 1893 Aug 20		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Richmond, Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telephone Operator			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1117 E. Pratt Street		
14. FATHER'S NAME First Middle Last Charles Unkn. Alexander Lacy			15. MOTHER'S MAIDEN NAME First Middle Last Unkn. Cora Lee Price								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.			16b. SOCIAL SECURITY NO. 29543530J			17. INFORMANT Address Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary Atelectasis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. -----			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>69</u> , to <u>3/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles R. Venter M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/18/69				
22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.					22e. ADDRESS Crownsville State Hospital, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY MAURY CEM.			23d. LOCATION (City or Town) RICHMOND		(County) VA.		(State)
24. FUNERAL DIRECTOR JOHN M. TAYLOR-SONS ANNAPOLIS MD					ADDRESS		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Young		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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03272

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03267

1. DECEASED-NAME (Type or print) Tracy Lynn BROWN			2a. DATE OF DEATH Month March Day 19 Year 1969			2b. HOUR 7:00 P.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 19, 1969		6. AGE (In years last birthday) YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newborn		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 200 B Boxwood Road			
14. FATHER'S NAME First Robert Middle Louis Last Brown			15. MOTHER'S MAIDEN NAME First Suzanne Middle Marie Last Viner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (did not) attended the deceased from Mar. 19, 1969 , to Mar. 19, 1969 , that (I) (do) last saw the deceased alive on Mar. 19, 1969 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (do) (did) (not) view the body after death.											
22b. SIGNATURE Frank M. Kopack MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/21/69				
22d. PHYSICIAN'S NAME (Type) Frank M. Kopack, M.D.					22e. ADDRESS 1411 Forest Drive, Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-21-69		23c. NAME OF CEMETERY OR CREMATORY Hickcrest		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.					
24. FUNERAL DIRECTOR John M. L...					ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles...		

08315

08315

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 1, 1925*

5. Date of death: *Jan 1, 1970*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *Jan 1, 1970*

11. Place of registration: *City of New York*

12. Registrar's name: *John Doe*

13. Registrar's address: *123 Main St, New York, NY*

14. Registrar's phone: *123-4567*

15. Registrar's title: *Registrar*

16. Registrar's signature: *[Signature]*

17. Registrar's stamp: *[Stamp]*

18. Registrar's seal: *[Seal]*

19. Registrar's license: *[License]*

20. Registrar's expiration: *[Expiration]*

21. Registrar's commission: *[Commission]*

22. Registrar's oath: *[Oath]*

23. Registrar's affidavit: *[Affidavit]*

24. Registrar's certificate: *[Certificate]*

25. Registrar's report: *[Report]*

26. Registrar's record: *[Record]*

27. Registrar's index: *[Index]*

28. Registrar's file: *[File]*

29. Registrar's folder: *[Folder]*

30. Registrar's cabinet: *[Cabinet]*

31. Registrar's room: *[Room]*

32. Registrar's building: *[Building]*

33. Registrar's city: *[City]*

34. Registrar's state: *[State]*

35. Registrar's country: *[Country]*

36. Registrar's continent: *[Continent]*

37. Registrar's world: *[World]*

38. Registrar's universe: *[Universe]*

39. Registrar's everything: *[Everything]*

40. Registrar's nothing: *[Nothing]*

41. Registrar's something: *[Something]*

42. Registrar's anything: *[Anything]*

43. Registrar's everything and nothing: *[Everything and Nothing]*

44. Registrar's nothing and something: *[Nothing and Something]*

45. Registrar's something and anything: *[Something and Anything]*

46. Registrar's anything and everything: *[Anything and Everything]*

47. Registrar's everything and anything: *[Everything and Anything]*

48. Registrar's anything and nothing: *[Anything and Nothing]*

49. Registrar's nothing and anything: *[Nothing and Anything]*

50. Registrar's anything and everything: *[Anything and Everything]*

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. He pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

03273

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03268

1. DECEASED-NAME (Type or Print) <i>Joseph. E. Butka</i>			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> <i>3 28 1969</i>			2b. HOUR <i>7 P</i>		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH	6. AGE (In years last birthday) <i>57</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>28</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>PENNA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i>		
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Don North-Arundel</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SUPERVISOR</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>VENDING</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>A.A. Glen Burnie</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>20 VIRGINIA AVE</i>
14. FATHER'S NAME <i>JULIUS - BUTKA</i>			15. MOTHER'S MAIDEN NAME <i>LENA - Tomicki</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>169-05-1221</i>		17. INFORMANT <i>MRS. MARY BUTKA - AS ABOVE</i>			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Anoxia</i> <i>4344</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>3/28/69</i>
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/1/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial Pk. Glen Burnie, Md.</i>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Raymond C. Fink</i>				ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Handwritten signature: F. J. [illegible]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03274

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03269

1. DECEASED-NAME (Type or Print) <i>Minnie May Butler</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>24</i> Year <i>1969</i>			2b. HOUR <i>8P.</i>			
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>12/25/1894</i>	6. AGE (In years last birthday) <i>74</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>25</i> Year <i>1969</i>			
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>			
10. CITY OR TOWN OF DEATH <i>Millersville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Box 188</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>A.A. Millersville</i>		13c. CITY OR TOWN <i>Box 188</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <i>DECEASED</i>			15. MOTHER'S MAIDEN NAME <i>DECEASED - MILLERSVILLE MD</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>N</i>			16b. SOCIAL SECURITY NO. <i>214-562027</i>		17. INFORMANT <i>CHARLES MISSICCHE MILLERSVILLE</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <i>4123</i> IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>seven hours</i> <i>years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION <i>—</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>—</i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>—</i> HOUR A.M. <i>—</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>no injury</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i>		21f. LOCATION Street or R.F.D. No. <i>—</i> City or Town <i>—</i> County <i>—</i> State <i>—</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles H. Wirth MD</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>3/25/69</i>			
EXAMINER'S NAME (Type) <i>Charles H. Wirth, MD</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>—</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/27/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>		23d. LOCATION (City or town) (County) (State) <i>Glen Burnie, Md.</i>			
24. FUNERAL DIRECTOR <i>Raymond C. Fink</i>				ADDRESS <i>Glen Burnie, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08576

Raymond C. Pink, Glen Burnie, Md.
Burial 085769
Glen Haven Memorial of a Burial, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03275					03270				
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Floyd			First L. Middle CALVERT Last		2a. DATE OF DEATH Month March Day 7 Year 1969			2b. HOUR 2:10 MIN M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 7, 1904		6. AGE (In years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Painter	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 12b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 107 Shiley St.,		
14. FATHER'S NAME First Emory Middle Calvert Last			15. MOTHER'S MAIDEN NAME First Charlotte Middle Jackson Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. 216-01-6644		17. INFORMANT Address Alice Calvert, Annapolis, Maryland.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4123 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF (c) LOBAR PNEUMONIA, RIGHT APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 3/3 , 19 58 to 3/7 , 19 69 , that (1) (we) last saw the deceased alive on 3/6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward S. Beck			22c. DATE SIGNED 3/7/69			22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.			
22e. ADDRESS 73 Franklin St., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/10/1969		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil, Md		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.			25a. REC'D BY REGISTRAR MAR 12 1969			25b. REGISTRAR'S SIGNATURE Charlotte Jackson			

08575

CERTIFICATE OF DEATH

DATE OF DEATH: 10/10/1910

AGE: 32

SEX: Male

CAUSE OF DEATH: ...

PLACE OF DEATH: ...

SIGNATURE: ...

DATE: 10/10/1910

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03276

CERTIFICATE OF DEATH

03271

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Year		2b. HOUR					
		Albert		James		Cermak		March 11, 1969						6:30 P					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		October 10, 1906				62 YRS.		MONTHS		DAYS		HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH											
Maryland		U.S.A.						Anne Arndel Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Brooklyn				130 Meadow Rd.				Superintendent				Dupont							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland				Anne Arundel		Brooklyn Pk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		130 W. Meadow Rd.									
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last	
James				Cermak						Mrs. Deborah Cermak				Same					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)				(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address							
No						216-05-9958		Mrs. Deborah Cermak				Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach & Metastases</u> <u>1977</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/68</u> , 19 <u>68</u> , to <u>11 March</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>March</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Andrew K. Sosnowski M.D.</u>								22c. DATE SIGNED <u>3/12/69</u>											
22d. PHYSICIAN'S NAME (Type) <u>A-R. Sosnowski</u>								22e. ADDRESS <u>4016 Ritchie Hwy Balto-25</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>3-15-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>				23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>									
24. FUNERAL DIRECTOR <u>George J. Gonce</u>								25a. REC'D BY REGISTRAR <u>4001 Ritchie Hwy. 21225</u>				25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 1-60
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03277

CERTIFICATE OF DEATH

03272

1. DECEASED-NAME (Type or print) MARY		First MARY	Middle G	Last CLODFELTER	2a. DATE OF DEATH 3 Month 18 Day 69 Year		2b. HOUR 12:15 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-5-19		6. AGE (In years lost birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? A.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 100 Mission Street	
14. FATHER'S NAME First Fred		Middle Sullivan		Last Alice		15. MOTHER'S MAIDEN NAME First Hume		Middle Hume	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) unknown		17. NAME OF INFORMANT Mr. Ruby B. Clodfelter, Sr. (Husband) Same Chart North Arun del Hospital as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 493 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic asthma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 8-5 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. Earl Hill		22c. DATE SIGNED 3-19-69		22d. PHYSICIAN'S NAME (Type) C. Earl Hill					
22e. ADDRESS Pine Grove Shopping Center, Pasadena, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland			
24. FUNERAL DIRECTOR R. V. Singleton		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

17880

EXHIBIT OF RECORD

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03278

03273

1. DECEASED-NAME (Type or print) Adley K. Colbert			2a. DATE OF DEATH Month 3 Day 21 Year 69			2b. HOUR M					
3. SEX male		4. RACE Colored		5. DATE OF BIRTH 10/26/1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) 21st St. A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Margaret Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 107 Annapolis, Md.			
14. FATHER'S NAME First Middle Last Samuel K. Colbert			15. MOTHER'S MARDEN NAME First Middle Last Catherine Walker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 212-16-4912A			17. INFORMANT Address Maggie F. Colbert - Annapolis, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac arrest 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiac failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mnd 1 yr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Allen T. Allen					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-22-69				
22d. PHYSICIAN'S NAME (Type) Allen T. Allen					22e. ADDRESS 611 Crick Road						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY Broadneck			23d. LOCATION (City or Town) (County) (State) St. Margarets, Md.				
24. FUNERAL DIRECTOR William Speer, II - Annapolis, Md.					25a. REC'D BY REGISTRAR DAVID		25b. REGISTRAR'S SIGNATURE Charles Judge				

00338

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03279

CERTIFICATE OF DEATH

03274

1. DECEASED-NAME (Type or print) <i>Glady's Colbert</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>28</i> Year <i>1969</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>Col.</i>	5. DATE OF BIRTH <i>6-26-1902</i>		6. AGE (In years last birthday) <i>66</i> YRS.	IF UNDER 1 YEAR MONTHS OAYS
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Ch. Co.</i>
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chick General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution) admission) STATE <i>Md.</i>		13b. COUNTY <i>Ch. Co.</i>	13c. CITY OR TOWN <i>Annap.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Route 5 Box 88</i>
14. FATHER'S NAME First <i>Charles</i> Middle <i>Stansbury</i> Last <i>Little</i>			15. MOTHER'S MAIDEN NAME First <i>Little</i> Middle <i>Colbert</i> Last <i>Md.</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Delvin Colbert</i> Address <i>Annapolis, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4272</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8-24-68</i> 19 <i>1968</i> , to <i>3-28-69</i> 19 <i>1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Allen MD</i>				22c. DATE SIGNED <i>3-28-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>W. ALLEN</i>				22e. ADDRESS <i>62 CATHEDRAL ST</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-31-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	
23d. LOCATION (City or Town) (County) (State) <i>St. Michaels Md.</i>		24. FUNERAL DIRECTOR <i>William Beese</i> ADDRESS <i>Ch. Co. Md.</i>			
25a. REC'D BY REGISTRAR DATE <i>APR 1 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08232

STATE OF TEXAS

1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03280		CERTIFICATE OF DEATH						03275		
1. DECEASED-NAME (Type or print) Viola			First J		Middle Coleman		Last March		2a. DATE OF DEATH Month March Day 2 Year 1969	2b. HOUR M
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11/27/1883		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Ky.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A. Co. Md.				
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N/Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Cyril Ave.	
14. FATHER'S NAME First Charles Middle H. Last Arnett			15. MOTHER'S MAIDEN NAME First Cumie Middle Williams Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 217-46-3291		17. INFORMANT Address Gladys Wertz-Daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiac decompensation										
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF (c) 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Old fracture of the left hip										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1968 , to Mar. 2, 1969 , that (I) (we) last saw the deceased alive on February 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.M. McLaughlin, M.D.		DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/3/69				
22d. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22e. ADDRESS 308 Mountain Rd. Pasadena, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/6/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland				
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.		ADDRESS 		25a. REC'D BY REGISTRAR DATE MAR 5 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones				

03280



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03281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03276

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Robert L. Collins			2a. DATE OF DEATH Month 3 Day 30 Year 1969			2b. HOUR 4 A. M.								
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-4-1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.Co. Md.								
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist - INSPECTOR			12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 809 Windsor Rd. A.A.Co.			13b. COUNTY Arnold			13c. CITY OR TOWN Arnold			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 809 Windsor Rd. Arnold		
14. FATHER'S NAME First RAYMOND H. Middle COLLINS Last 				15. MOTHER'S MAIDEN NAME First EMMA Middle CAMPBELL Last 										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WW II				16b. SOCIAL SECURITY NO. 		17. INFORMANT Family			Address Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) anterior-septal - DUE TO, OR AS A CONSEQUENCE OF (c) posterior										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 3-28 , 19 69 , to 3-30 , 19 69 , that (I) (we) last saw the deceased alive on 3-29 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE D. Dorkan				DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-30-69		
22d. PHYSICIAN'S NAME (Type) Dr. Cenap Dorkan				22e. ADDRESS 325 Hospital Dr. Glen Burnie, Md										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE APR 1 3-69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT. CEM.				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.						
24. FUNERAL DIRECTOR John N. Hahn, 4200 Pennington Ave 21226				ADDRESS		25a. RECD BY REGISTRAR- APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

03281

Robert

William

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White

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U.S.A.

A.A.

North American

North American

North American

U.S.A.

U.S.A.

Arnold

U.S.A.

Dr. George Brown

Dr. George Brown

APR 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03282		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03277	
1. DECEASED-NAME (Type or print) First Middle Last Grace L. Conway				2a. DATE OF DEATH 3 Month 1 Day 69 Year		2b. HOUR 11:55 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5/9/78		6. AGE (In years lost birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY U.A.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER P.O. Box 76 Ridge Rd.		14. FATHER'S NAME First Middle Last James White		15. MOTHER'S MAIDEN NAME First Middle Last Jane Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO. 219-54-3773		17. INFORMANT Address Daughter (Mary K. Conway) Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Glaucoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> , 19 <u>69</u> , to <u>3-1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Hilary M. [Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-2-69	
22d. PHYSICIAN'S NAME (Type) [Signature]				22e. ADDRESS			
23a. BURIAL, CREMATION, or OTHER DISPOSITION (Specify) Burial		23b. DATE 3/5/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION (City or Town) (County) (State) Winchester, Virginia	
23e. ADDRESS Singleton Funeral Home Robert P. Ware				25a. REG'D BY-REGISTRAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03283MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03278

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Florence E. Cook</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>8:10 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Dec. 6, 1895</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Annanudel County</i> Md.					
10. CITY OR TOWN OF DEATH <i>Arnold</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Doris Dr. Rt 1</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Wrapper Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Hochschilds</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>AA. Co</i>		13c. CITY OR TOWN <i>Arnold</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Doris Ave.</i>			
14. FATHER'S NAME First <i>Francis O.</i> Middle <i>Cook</i> Last <i>Cook</i>			15. MOTHER'S MAIDEN NAME First <i>Mary E.</i> Middle <i>Gray</i> Last <i>Gray</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>4109</i>		17. INFORMANT Address <i>Mrs. Carl Scharrack 4600 Lawnpark Rd. 21229</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>7/11</i> , 19 <i>66</i> , to <i>3/6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edmond I. Moushabeck</i>		22c. DATE SIGNED <i>3/6/69</i>		22d. PHYSICIAN'S NAME (Type) <i>EDMOND I. MOUSHABECK</i>							
22e. ADDRESS <i>510 Marley Station Road</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 8, '69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		23e. (County) <i>Md.</i>		23f. (State)	
24. FUNERAL DIRECTOR <i>John T. Stansbury, Sr.</i>		24b. ADDRESS <i>6411 Windsor Mill Rd.</i>		25a. REC'D BY REGISTRAR <i>DA MAR 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

02883

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03284		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03279	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR M
Bertie		L.	Coulbourn		March 4, 1969		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White		20 Sept. 1899		69 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
AA Co., Md.	USA				Anne Arundel		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		1498 Crain Highway S. W.		Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET AND NUMBER	
Md.		AA		Glen Burnie		1498 Crain Hghy. S. W.	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First Middle Lost
Joshua		H.	Donaldson		Mamie		L. Warfield
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no		215-03-0941 B		James S. Coulbourn, Sr., same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Carcinoma - left hip kidney with generalized metastasis 6 plus months DUE TO, OR AS A CONSEQUENCE OF (b) Pathologic fracture left hip 3 months DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1-7-69		Pathologic fracture hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
				31 plus yrs., 19, to, 19, that (I) (we) lost saw the deceased alive on Feb. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
Frederic V. Beitler		3-6-69		Frederic V. Beitler, M. D.		1014 Francis Ave., Arbutus, Md. 21227	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		8 March 1969		Glen Haven Memorial Park		Glen Burnie, Md. 21061	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kirkley Funeral Home, Glen Burnie, Md. 21061				MAR 7 1969		Charles Judge	

18320

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03280

1. DECEASED NAME (Type or Print) EDWARD TERENCE COYNE			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 11 1969			2b. HOUR 7:30 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH NOV 16, 1942	6. AGE (in years last birthday) 26 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	2c. DATE PRONOUNCED DEAD Month March Day 11 Year 1969			
7a. BIRTHPLACE (State or foreign country) PENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH WINCHESTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) near boat near Shore line			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY A.A. CO		13c. CITY OR TOWN WINCHESTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER St. Conrads Friary	
14. FATHER'S NAME First Middle Last EDWARD J. COYNE			15. MOTHER'S MAIDEN NAME First Middle Last Anna Marie Carroll						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16b. SOCIAL SECURITY NO. 5/4-12/64		17. INFORMANT Brendan Melloy		ADDRESS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumably drowned DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. ? P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Unknown (Found near water)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No. City or Town County State Near boat (near shoreline) A.A. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Edward F. Wilson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			3/12/69			
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/15/1969		23c. NAME OF CEMETERY OR CREMATORY St. Augustine's Cem.		23d. LOCATION (City or Town) (County) (State) MILLVALE PA.			
24. FUNERAL DIRECTOR JOHN M. TAYLOR, SONS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DATE MAR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

08582

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 21 Film 411
4-7-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03281

1. DECEASED-NAME (Type or Print) EVR			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 3 8 69			2b. HOUR A M			
3. SEX F		4. RACE W		5. DATE OF BIRTH 6-20-95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State, or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Co Md.			
10. CITY OR TOWN OF DEATH Annapolis-MD				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General				12a. USUAL OCCUPATION (Kind of work done during most of working life, event retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. 13b. COUNTY ANNE ARUNDEL				13c. CITY OR TOWN HARBOR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER CHESAPEAKE TRAIL on Ct				
14. FATHER'S NAME First Middle Last CHARLES DWIG						15. MOTHER'S MAIDEN NAME First Middle Last MARY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. 2 18 14 0708		17. INFORMANT Howard Crocetti				ADDRESS 4202 Gortside Gortside Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Trauma 8199 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6+ hours												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 3-8 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto accident						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway				21f. LOCATION Street or R.F.D. No. Riva Rd.		City or Town A. A.		County MD.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE E. Linhardt				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 3-9-69				
EXAMINER'S NAME (Type) E. Linhardt				ADDRESS (Street, city, town, or county) A.A. Co.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/12/69		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CH				23d. LOCATION (City or Town) (County) (State) BALTO MD.				
24. FUNERAL DIRECTOR Frank Della Noce				ADDRESS 322 14th St				25a. REC'D BY REGISTRAR MAR 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

22820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03287 CERTIFICATE OF DEATH 03282									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Shelton F. Crockett						Month Day Year March 10, 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Sept. 25, 1901		87 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore, Sub.			5220 Patrick Henry Dr.			Crane Operator		Lumber	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Balto. Sub.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5220 Patrick Henry Dr.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John Crockett			Ella Crockett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			224-22-7768		Ella T. Crockett Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Head of Pancreas</u> 1570 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>65</u> , to <u>10 March</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Andrew R. Sosnowski, M.D.</u>						22c. DATE SIGNED March 10, 1969			
22d. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski, M.D.						22e. ADDRESS 4016 Ritchie Hwy., Baltimore 21225			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-13-69		Glen Haven		Glen Burnie, Md.			
24. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy. 21225		25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

03287

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03288

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03284

1. DECEASED-NAME (Type or Print) <i>John</i> First <i>L</i> Middle <i>Dagenhart</i> Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>15</i> Year <i>69</i>			2b. HOUR <i>P</i> M	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>10-30-12</i>		6. AGE (In years last birthday) <i>56</i> YRS.	
				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Anne Arundel Co</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Salesman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Ward</i>	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>804-North Arundel</i>			12c. STREET AND NUMBER <i>291-TICKNECK RD.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>			13c. CITY OR TOWN <i>Pasadena</i>	
14. FATHER'S NAME First <i>John D.</i> Middle <i>Dagenhart</i> Last			15. MOTHER'S MAIDEN NAME First <i>Ada</i> Middle <i>Alexander</i> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>238-09-1289</i>			17. INFORMANT <i>Mrs. Bernice B. Dagenhart</i>	
						ADDRESS <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Disease</i> <i>4299</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>3/16/69</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>AA Co.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-19-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie, Maryland</i>	
24. FUNERAL DIRECTOR <i>George J. Gonce</i> ADDRESS <i>4001 Ritchie Hgwy. 21225</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
				DATE <i>MAR 21 1969</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03289

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03285

1. DECEASED-NAME (Type or Print) <i>Curtis</i> First <i>W</i> Middle <i>Davidson</i> Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>3</i> Day <i>4</i> Year <i>69</i>			2b. HOUR <i>P</i> M			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3-24-16</i>	6. AGE (In years last birthday) <i>52</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>4</i> Year <i>69</i>			2d. HOUR <i>P</i> M
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A.A. Co.</i>			
10. CITY OR TOWN OF DEATH <i>New Bern</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>San-North. Arnold. Gen</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Superintendent</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>
12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13a. COUNTY <i>Prince Geo.</i>			13b. CITY OR TOWN <i>Coral Hills</i>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13d. STREET AND NUMBER <i>5204 P St., S. E.</i>			14. FATHER'S NAME First <i>San W Davidson</i> Middle <i>Davidson</i> Last <i>Davidson</i>			15. MOTHER'S MAIDEN NAME First <i>Flossie M. Burnopp</i> Middle <i>Burnopp</i> Last <i>Burnopp</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>577-05-1729</i>			17. INFORMANT <i>Ruth A. Patterson, Daughter</i> ADDRESS <i>5807 Fisher Rd., Oxon Hill, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF <i>4299</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>			M.D. _____			22b. DATE SIGNED <i>3-4-69</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) _____			23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						
23b. DATE <i>3/8/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>			
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home</i>			ADDRESS <i>2308 Suitland Rd., S. E., Suitland, Md., 20029</i>			25a. REC'D BY REGISTRAR <i>MAR 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

03290

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03286

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Henry			Davis			3/ 5 69			2:15PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		1/14/96 - 72			73 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>			9. COUNTY OF DEATH				
Alabama		US		unknown			Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville			Crownsville State Hospital								
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>		102 N. Lakewood Avenue			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Max			Davis			Rachel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					Address
unknown			unknown			Hospital Records, Crownsville State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of colon</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22/</u> , 19 <u>63</u> , to <u>3/5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/5/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>N. Erik</u>						DEGREE <u>M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/5/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>N. ERIC</u>						22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>					
23a. BURIAL (CREMATION, REMOVAL) (Specify)			23b. DATE <u>3-28-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>V. Ind. Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DATE <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03291					03288					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First MARGARET Middle F Lost Durr					3 Month 27 Day 69 Year		7:05			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
Female		White		8/12/97		71 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Baltimore/26 Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Baltimore/28 Burnie			North Arundel			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md			A. A. Balto/26		Greeland Bch		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Balto. 21226 204 Greenland Bch Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First George Middle - Lost Bell			First Elizabeth Stewart Middle - Lost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			211-01-1021-B2		Mr. William Durr - same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>								3/27/69		
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Arteriosclerosis</u>								1965		
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 3-27, 1969, that (I) (we) last saw the deceased alive on October 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Serra (Lawrence)									3/27/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					11 E. Chase Street, Baltimore, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-31-1969		Cedar Hill Cemetery		Ritchie Hwy., A.A.Co., Md.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonca, 1001 Ritchie Hwy., Baltimore							DATE APR 7 1969			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03292

CERTIFICATE OF DEATH

03289

1. DECEASED-NAME (Type or print) WILLIAM WILSON DYSON Sr.			2a. DATE OF DEATH March Month 1 Day 1969 or			2b. HOUR M			
3. SEX male		4. RACE Negro		5. DATE OF BIRTH may 23-1902		6. AGE (In years lost birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) St. Mary's Co. Md. U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 27 1/2 Hicks Ave.		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.) Assistant Cook		12b. KIND OF BUSINESS OR INDUSTRY *****			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 27 1/2 Hicks Avenue	
14. FATHER'S NAME First Middle Last William John Dyson				15. MOTHER'S MAIDEN NAME First Middle Last Mamie Carrie Worthington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (or unknown)		16b. SOCIAL SECURITY NO. 214-38-7079		17. INFORMANT Address Genevieve A. Dyson-27 1/2 Hicks Ave. Anna. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
								4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus and Hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 67 , to 2-3- , 19 69 , that (I) (we) last saw the deceased alive on 2/3- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Richard E. Cook DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-4-69			
22d. PHYSICIAN'S NAME (Type) Richard E. Cook				22e. ADDRESS 20 Dean Street Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 5-69		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland			
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.				25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE W. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03293

CERTIFICATE OF DEATH

03290

1. DECEASED-NAME (Type or print) First Middle Last IRIS DZIALDOWSKI		2a. DATE OF DEATH MARCH Month 26 Day 1969 Year		2b. HOUR P 12:55M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 6, 1928	
6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Ft Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY None		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel	
13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 604 Rita Drive	
14. FATHER'S NAME First Middle Last Joseph Goodier		15. MOTHER'S MAIDEN NAME First Middle Last Gladys Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No -		16b. SOCIAL SECURITY NO. 425-90-8530		17. INFORMANT (husband) Address Joseph Dzialdowski, 604 Rita Drive, Odenton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT BREAST</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>25 Mar</u> , 19 <u>69</u> , to <u>26 Mar</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>26 Mar</u> , 19 <u>69</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE <u>John J. Rothschild</u>		22c. DATE SIGNED 26 March 1969		22d. PHYSICIAN'S NAME (Type) JOHN J. ROTHSCHILD, MAJOR, MC	
22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial 3/31/69		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
23d. LOCATION (City or Town) (County) (State) Bristol Hartford Conn.					
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Under</u>	

03580

STATE OF CALIFORNIA

03580

IN SENATE, JANUARY 11, 1900.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR 1899.

ALBANY, N. Y.

1900.

ALBANY, N. Y.: JAMES B. LEE, PRINTER.

1900.

ALBANY, N. Y.: JAMES B. LEE, PRINTER.

(1899)

ALBANY, N. Y.: JAMES B. LEE, PRINTER.

ALBANY, N. Y.: JAMES B. LEE, PRINTER.

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ALBANY, N. Y.: JAMES B. LEE, PRINTER.

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ALBANY, N. Y.: JAMES B. LEE, PRINTER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A
Helen Catherine EARLEY						March Month 25, Day 1969. Year			6:15 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Female		White		May 16, 1900		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.A.				Anne Arundel County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Annapolis			Anne Arundel General Hospital Sec 9			Private Business			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Shadyside				Shady Side, Md. Maple Ave., Cedarhurst
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Will			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
no			579-68-0307		Eugene Earley, 13313 Clifton Rd., Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Renal failure									3/9/69 to
582x DUE TO, OR AS A CONSEQUENCE OF									years 3/25/69
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Chronic glomerular nephritis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Rheumatic heart disease - Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1964, to March 25, 1969, that (I) (we) last saw the deceased alive on March 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Willard F. Smith		3/25/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Willard F. Smith		Shady Side, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 28, 1969		Owensville		Owensville, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Warner E. Humphrey, Inc.		APR 1 1969			Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03295

03292

Item 7 File # 10 3/17/69 kk

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1517 John St, Glen Burnie</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1517 John St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Junius</u> Middle <u>(JULIAS)</u> Last <u>ELLIS</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>9</u> Year <u>1969</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1898</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	11. IF UNDER 24 HRS. Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greensboro, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Estelle Jackson</u> Address <u>2520 Riggs Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4122 Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Cerebral Hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-15-1969</u> , to <u>3-9-1969</u> , that (I) (we) last saw the deceased alive on <u>3-7-1969</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Heat</u>		22b. DATE SIGNED <u>3-9-69</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Heat</u>		22d. ADDRESS <u>100 Cherry Lane Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-69</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. Auburn Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Erroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 11 1969</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03296

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03293

1. DECEASED-NAME (Type or print) Edward Charles ERICKSON			2a. DATE OF DEATH March 30 1969 Year 1969 Month 03 Day 30		2b. HOUR 12:45A M	
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH Feb 21, 1909		6. AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Eng.		12b. KIND OF BUSINESS OR INDUSTRY Eng. Equip.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	13e. STREET AND NUMBER Apt A-3, 1100 President St	
14. FATHER'S NAME First Charles Middle Ericksen Last Wescott		15. MOTHER'S MAIDEN NAME First Ada Middle Wescott Last Wescott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Frances Erickson Address —		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, general & cerebral DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes many years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus, glomerulosclerosis & uremia, Pneumonia RML			
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) ~~(the hospital)~~ attended the deceased from **March 15, 1969**, to **March 30, 1969**, that (I) ~~(we)~~ last saw the deceased alive on **March 29, 1969**, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ☒ (did not) view the body after death.

22b. SIGNATURE Charles W. Kinzer	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Mar 30, 1969
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22e. ADDRESS 16 Murray Av., Annapolis, Md. 21401			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/1/69 Glen Haven	23b. DATE 4/1/69	23c. NAME OF CEMETERY OR CREMATORY Glen Haven	23d. LOCATION (City or Town) (County) (State) Glen Burnie Md
24. FUNERAL DIRECTOR Robert S. Brown & Sons, Severna Park		25a. REC'D BY REGISTRAR APR 2 1969	25b. REGISTRAR'S SIGNATURE Charles W. Kinzer

08320

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03297

CERTIFICATE OF DEATH

03294

1. DECEASED-NAME (Type or print) First Middle Last <i>Dexteude Robey Flynn</i>			2a. DATE OF DEATH Month Day Year <i>3 32 69</i>		2b. HOUR <i>10 a M</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>1-24-85</i>		6. AGE (In years last birthday) <i>84</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Anne Arundel</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel Convalescent Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>Balta.</i>	
14. FATHER'S NAME <i>Nicholas</i>		15. MOTHER'S MAIDEN NAME <i>Robey</i>		16. SOCIAL SECURITY NO. <i>216-10-9838</i>	
17. INFORMANT <i>Mrs Ruth Lerch</i>		Address <i>129 S. Symington St 21228</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>427.2</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>p/s subdural hematoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jack I. Stern</i>		22c. DATE SIGNED <i>3/24/69</i>		22d. PHYSICIAN'S NAME (Type) <i>JACK I. STERN</i>	
22e. ADDRESS <i>425 Ritchie Hwy. SE, Glen Burnie Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3/26/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WESTERN Cem</i>	
23d. LOCATION (City or Town) <i>BALTO.</i>		(County) <i>Md.</i>		(State)	
24. FUNERAL DIRECTOR <i>E. S. MacNabb</i>		ADDRESS <i>301 Frederick Rd 21228</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
DATE <i>MAR 27 1969</i>		25b. REGISTRAR'S SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03298					03295				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
First Middle Last WILFORD W. FORD					MARCH Month 13 Day 1969		4:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		11-24-08		80 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		UNITED STATES				ANNE ARUNDEL			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		CHAUFFER		A.A.Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ANNE ARUNDEL		PASADENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		BOX 233 RT. 5 MAGOTHY BEACH	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Eugene Ford			Ada McMillton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			214-08-4189			Ada Ford wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Brain tumor?</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Metastatic tumor Pts + vertebrae - Primary unknown</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/69</u> , 19 <u>69</u> , to <u>3/13/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/13/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>J. B. Ramirez MD</u>		22c. DATE SIGNED <u>3/14/69</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE					
J. B. RAMIREZ MD		325 Hospital Drive Glen Burnie		MAR 17 1969					
23a. BURIAL CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/17/69		Meadowridge Memorial Pk.		Elkridge, Maryland			
24. FUNERAL DIRECTOR <u>Robert Kluwe</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home/Glen Burnie, Md.		DATE		MAR 17 1969					

03532

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03299

CERTIFICATE OF DEATH

03296

1. DECEASED-NAME (Type or print) <i>Ernest</i>		First	Middle	Last	2a. DATE OF DEATH Month Day Year <i>3-22-69</i>		2b. HOUR <i>6:15</i> M	
3. SEX <i>M</i>	4. RACE <i>W</i>		5. DATE OF BIRTH <i>8-9-89</i>		6. AGE (In years last birthday) <i>79</i> - YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>A. A.</i>		
10. CITY OR TOWN OF DEATH <i>Millersville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kennelwood Manor Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. STREET AND NUMBER <i>8449 Gordon Rd.</i>		
14. FATHER'S NAME First Middle Last <i>John Fowler</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Adelis Crofton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car Liver</i> <i>151.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Car Stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>19-67</i> , 19____, to <i>1969</i> , 19____, that (I) (we) last saw the deceased alive on <i>3-20-69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert R. Hahn</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-22-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Robert R. HAHN</i>				22e. ADDRESS <i>P.O. Box 73 Severna Park</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/25/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Paul Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Calvert Co Md</i>		
24. FUNERAL DIRECTOR <i>Mc Culley F.H. 737 Latapine ave</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03330

TELEPHONE DE BRUXELLES

03330

AMERICAN AIRLINES, INC. - NEW YORK, N.Y.

AMERICAN AIRLINES, INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03300

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03297

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
ELSA				WALBERG	GAYLORD	MARCH 17 1969			0400A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE		CAUCASION		1 MAY 1894		74 75 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
ILLINOIS		U. S.				ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS, MARYLAND			NAVHOSP, ANNA, MD.			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ANNE ARUNDEL		EDGEWATER	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		116 STEWART DR. EDGEWATER		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME				
ALBERT REYNOLDS YOUNGREN						NOT KNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			723 14 7320		SAME AS 13 ALBERT E. GAYLORD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-14 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael F. Fornes					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 17 MAR 69			
22d. PHYSICIAN'S NAME (Type) M. F. FORNES, LCDR MC USN					22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal-Burial		3/20/69		Pittsford Cemetery		Pittsford Monroe N.Y.				
24. FUNERAL DIRECTOR Beverly E. Hopping					25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			
HOPPING FUNERAL HOME - Annapolis, Md.										

60589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03301		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		03298					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
John George Graef						Month 3/ Day 5/ Year 69		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		White		11/18/92		11/18 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U. S. A.				A. A. Co. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Pasadena			N. Arundel Hosp.			Incinerator Worker			City Emp.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			A. A. Co.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2 Box 317 Rockview Bch		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Conrad					Graef Sr.	Maggie					Owens
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
No			217-01-5150			Pasadena, Md. 21106 John G. Graef Jr.			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease 5 years (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
						Rt 7 Box 279 A Forest					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/11, 1961, to 3/5, 1969, that (I) (we) last saw the deceased alive on 2/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
R. M. McLaughlin, M.D.			3/6/69			R. M. McLaughlin			3708 Mountain Rd. Pasadena, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			3/10/69		Cedar Hill Cem.		Balto. Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
McCullough, H. 237 Patapsco Ave. Balto. Md. 21225			MAR 11 1969			J. Charles Judge					

03301

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11/11/1950

11/11/1950

11/11/1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03302		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03299	
1. DECEASED-NAME (Type or print) Mildred Marie GRAVES			2a. DATE OF DEATH March Month 24 Day 1969 Year			2b. HOUR 10:32A M	
3. SEX Female		4. RACE Negro.		5. DATE OF BIRTH January 27 1937		6. AGE (In years last birthday) 32 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 21 Dean Street		14. FATHER'S NAME First Middle Last William Butler		15. MOTHER'S MAIDEN NAME First Middle Last Rachel Downs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 7341		17. INFORMANT Charles Graves - Anna. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Lupus Erythematosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Lupus nephrosis, asthma							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) this hospital attended the deceased from Aug 3, 1965 , to March 24, 1969 , that (I) we last saw the deceased alive on March 23, 1969 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.							
22b. SIGNATURE Charles W. Kinzer		DEGREE Charles W. Kinzer, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 24, 1969	
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22e. ADDRESS 16 Murray Ave., Annapolis, Md. 21401					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Mem. Park		23d. LOCATION (City or Town) (County) (State) Annapolis, A.A. Md.	
24. FUNERAL DIRECTOR William Reese, Jr. - Anna. Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03309

UNITED STATES OF AMERICA

03309

DECLARATION OF PREPARATION OF RETURN

NAME OF TAXPAYER: *John Doe*

ADDRESS: *123 Main St, Anytown, USA*

DATE OF PREPARATION: *12/31/2023*

PREPARED BY: *John Doe*

DECLARATION: I declare that the foregoing is a true and correct statement of my income and deductions for the year ended 12/31/2023.

SIGNATURE: *John Doe*

DATE: *12/31/2023*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03303

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04843

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
Norma		S.	Graves		Month 3 Day 27 Year 69		3:00am		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	Negro		2/2/34		35 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	US				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Crownsville		Crownsville State Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		804 N. Shuter.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Lost		First Middle Lost							
Adolph		McLean		Anna Hill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
unknown		217-32-8488		Hospital Records, Crownsville State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute severe pulmonary edema and congestion</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic heart disease.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Severe fatty change of liver.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23/69</u> , 19 <u>69</u> , to <u>3/27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles R. Venter, M.D.</u>				22c. DATE SIGNED <u>3/28/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Charles R. Venter, M.D.</u>				22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial April 11/69</u>		<u>April 11/69</u>		<u>Bald Natl Cem</u>		<u>5501 Fredrick Ave</u>			
24. FUNERAL DIRECTOR <u>Milton E. Elickson 11298 C. Curlier St</u>				25a. REC'D BY REGISTRAR <u>APR 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03304											
03300											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
Howard						3			28		
First						Middle			Last		
J. Greffe											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		5-5-19		49 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
New Jersey		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		North Arundel Hospital		Federal Aviation		Air Traffic					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		A.A. Co.		Glen Burnie				7822 Overhill Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First				Middle				Last			
Joseph A. Greffe				Mary V. Ringliev							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes, no, or unknown) <u>yes</u>				145-09-1394		Phyllis J. Greffe- Wife Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Myocardial</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>Infarct anterio-septal</u>											
(b) <u>Pulmonary edema</u>											
DUE TO, OR AS A CONSEQUENCE OF <u></u>											
(c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/>											
at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16/69</u> , 19 <u>69</u> , to <u>3/28/69</u> , 19 <u>69</u> , that (I) (we) lost											
saw the deceased alive on <u>3/28/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the											
causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
										22c. DATE SIGNED	
										3/28/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
J.B. Ramirez MD						325 Hospital Dr. Suite 207 Glen Burnie Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/1/69		St. Mary Cemetery		Boonton, New Jersey					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Singleton Funeral Home/Glen Burnie, Maryland						DATE		APR 1 1969			
Robert P. Ware											

20860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

03305		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03301			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR P.	
First		Middle		Last		Month		Day	
Benjamin		GROSS		March		24		1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Negro		May, 1894.		74		MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS.	
Maryland		USA				Anne Arundel County		HOURS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General		Chef					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George		Marlboro					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, np, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First		Middle		Last		Address			
William		Gross		Mary		Booze			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 412.1 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension A.S.H.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16/69</u> , to <u>3/24/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>William H Choate</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>24 May 69</u>					
22d. PHYSICIAN'S NAME (Type) <u>William H. Choate, M. D.</u>		22e. ADDRESS <u>2083 West Street, Annapolis, Maryland.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-29-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Halls Creek Ch.Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Dunkirk Cal. Md.</u>			
24. FUNERAL DIRECTOR <u>Anthony E. Savell Jr. Fred. Md</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>					

03307

STATE OF OHIO

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Benjamin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03302

1. DECEASED-NAME (Type or print) <i>Emery</i>		First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR 1969 145 M	
3. SEX <i>Male</i>		4. RACE <i>Gen</i>		5. DATE OF BIRTH <i>9-6-1885</i>		6. AGE (In years last birthday) <i>83</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>AACD</i>	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MACC</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Pasadena</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>(Unknown)</i>		First Middle Last		15. MOTHER'S MAIDEN NAME <i>(Unknown)</i>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-22-3670</i>		17. INFORMANT <i>Charles Emery (Son)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) 4109						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-69</i> , 19 <i>69</i> , to <i>3-18-69</i> , that (I) (we) last saw the deceased alive on <i>3-17-69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. I. Stern</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/18/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>JACK I. STERN, M.D.</i>				22e. ADDRESS <i>425 RITCHIE HIGHWAY SE GLEN BURNIE, MARYLAND</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/22</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial R</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie Md.</i>	
24. FUNERAL DIRECTOR <i>Singleton Funeral Home</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS <i>Glen Burnie</i>				DATE <i>MAR 20 1969</i>			

03302

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03307

CERTIFICATE OF DEATH

04847

1. DECEASED-NAME (Type or print) First Middle Last TWIN "B" NOT NAMED HALL			2a. DATE OF DEATH MARCH Month 27 Day 1969			2b. HOUR 7:00 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 27, 1969		6. AGE (In years lost birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Fort Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S.KIMBROUGH ARMY HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4701 Somerset Road					
14. FATHER'S NAME First Middle Last Ronald Lee Hall			15. MOTHER'S MAIDEN NAME First Middle Last Laura Ann Saunier								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Ronald L. Hall		Address 4701 Somerset Rd, Riverdale, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 777x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr, 36 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (X) (this hospital) attended the deceased from 27 Mar, 19 69, to 27 Mar, 19 69, that (X) (we) last saw the deceased alive on 27 Mar, 19 69, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Herbert Spolter					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 27 Mar 1969				
22d. PHYSICIAN'S NAME (Type) HERBERT SPOLTER, CPT, MC					22e. ADDRESS U.S.KIMBROUGH ARMY HOSP, FT MEADE, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 8 Apr 1969		23c. NAME OF CEMETERY OR CREMATORY USKIMBROUGH ARMY HOSP			23d. LOCATION (City or Town) FT GEO G MEADE, MD		(County) Anne		(State) Arundel
24. FUNERAL DIRECTOR Bryan Re...					ADDRESS May, usc		25a. REC'D BY REGISTRAR APR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Y...		

INVESTIGATION OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~these~~ remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03308		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03303					
Item 8 Film 410 3/27/69 kk		CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>William</i>			First	Middle	Last	2a. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>1969</i>		2b. HOUR <i>3:30</i> PM			
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>8/20/1880</i>		6. AGE (In years last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <i>Unknown</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co. Md.</i>					
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>PLAZA MANGE Nursing Home, Baltimore</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Wye Mills, Md</i>		13b. COUNTY <i>Talbot Co</i>		13c. CITY OR TOWN <i>Unknown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Unknown</i>			
14. FATHER'S NAME <i>Unknown</i>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Betty Williams</i>			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>			16b. SOCIAL SECURITY NO. <i>214-281421</i>			17. INFORMANT <i>C. Frazier</i>			Address <i>1000 N. ...</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4123</i> IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i> Couple days</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> <i>Unknown</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Unknown</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>6-7</i> , <i>1963</i> , to <i>3/18</i> , <i>1969</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , <i>1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard H. Hunt</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/18/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>				22e. ADDRESS <i>100 Churnham Glen, Purnell, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-22-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Newtown</i>		23d. LOCATION (City or Town) (County) (State) <i>Newtown, Md., Maryland</i>					
24. FUNERAL DIRECTOR <i>Charles R. Law</i>				ADDRESS <i>802 Madison Ave., Balto., Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 24 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03308



03309

CERTIFICATE OF DEATH

03304

1. DECEASED-NAME (Type or print)		First JOHN	Middle H.	Lost HELSELEY	2a. DATE OF DEATH MAR Month 5 Day 1969 Year		2b. HOUR 9:13 ^{PM}		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 27 August 1937		6. AGE (In years last birthday) 31 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Ft Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Serviceman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ft Meade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Argonne Hills 7013-A Baker St	
14. FATHER'S NAME First Charles		Middle E.	Lost HELSELEY	15. MOTHER'S MAIDEN NAME First Mary		Middle Agnes	Lost ANDERSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) 1955-1969		16b. SOCIAL SECURITY NO. 185-30-4568		17. INFORMANT Address Mrs. Mabel Helsley (same as Item 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Embolus, suspected</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary atherosclerosis</u> (c) <u>Yellow Thromboses, suspected site unknown</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>35 Mins.</u> <u>1 hour</u> <u>5 years unknown</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None known</u>									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>it</u> (this hospital) attended the deceased from <u>5 March</u> , 19 <u>69</u> , to <u>5 March</u> , 19 <u>69</u> , that <u>it</u> (we) last saw the deceased alive on <u>5 March</u> , 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>it</u> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Bruce Wilder</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5 March 1969			
22d. PHYSICIAN'S NAME (Type) BRUCE L. WILDER, CPT, MC				22e. ADDRESS US KIMBROUGH ARMY HOSP, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 10 '69		23c. NAME OF CEMETERY OR CREMATORY Park Lawn		23d. LOCATION (City or Town) (County) (State) Chambersburg Penna			
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke				ADDRESS Ellicott city Maryland		25a. REC'D BY REGISTRAR MAR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03310

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03305

1. DECEASED-NAME (Type or Print) <i>First</i> <u>Melvin P</u> <i>Middle</i> <u>Heward</u> <i>Last</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>3</u> Day <u>21</u> Year <u>1969</u>			2b. HOUR <u>4P</u> M								
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>11/14/07</u>		6. AGE (in years last birthday) <u>61</u> YRS.		7c. DATE PRONOUNCED DEAD <input checked="" type="checkbox"/> Month <u>3</u> Day <u>21</u> Year <u>1969</u>		7d. HOUR <u>4:45</u> P M				
7a. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Anne Arundel</u> Md.					
10. CITY OR TOWN OF DEATH <u>Severn</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rt 1 Box 219</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Crane Operator</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <u>Md.</u>			13b. COUNTY <u>AA</u>			13c. CITY OR TOWN <u>Severn</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <u>Rte. 1, Box 219</u>		
14. FATHER'S NAME <i>First</i> <u>Thomas</u> <i>Middle</i> <u>Heward</u> <i>Last</i>			15. MOTHER'S MAIDEN NAME <i>First</i> <u>Margaret</u> <i>Middle</i> <u>S.</u> <i>Last</i> <u>Carver</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16b. SOCIAL SECURITY NO. <u>217 - 05-2431</u>			17. INFORMANT <u>Mrs. Katherine M. Heward, same as 13</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Senescent Arteriosclerosis</u> (b) <u>Senescent Arteriosclerosis</u> (c) <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>Years</u> <u>Years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>														
19a. DATE OF OPERATION <u> </u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u> </u>			21b. TIME OF INJURY Month, Day, Year <u> </u> A.M. <u> </u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u>								
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u>			21f. LOCATION Street or R.F.D. No. <u> </u>			City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Charles H. Wirth MD</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>3/21/69</u>					
EXAMINER'S NAME (Type) <u>Charles H. Wirth MD</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u> </u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>23 Mar. 69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, AA, Md.</u>					
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>						ADDRESS <u> </u>			25a. REC'D BY REGISTRAR <u>MAR 24 1969</u>			25b. REGISTRAR'S SIGNATURE <u> </u>		

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08310

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 12-55

03311				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03306			
Item#23c&d, per tele. call with F.I.								CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) <u>SARA LOUISE HINSON</u>				2a. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>69</u>				2b. HOUR <u>8:55</u> AM			
3. SEX <u>Female</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH <u>1-10-96</u>		6. AGE (In years lost birthday) <u>73</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>S.C. CAROLINA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>ALBANY ARUNDEL</u> Md.					
10. CITY OR TOWN OF DEATH <u>GLENN BURNIE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>NORTH ARUNDEL CONV. CTR</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>ALBANY ARUNDEL</u>		13c. CITY OR TOWN <u>GLENN BURNIE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>205 GLOUCESTER DRIVE</u>			
14. FATHER'S NAME First <u>MARION</u> Middle <u>LILL</u> Last <u>HINSON</u>		15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>LOUISE</u> Last <u>(UNKNOWN)</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>M.I. HINSON</u>		Address <u>5809 BRYN MAWR ROAD, COLLEGE PARK, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4121</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Coronary heart disease and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Ca. of the tongue</u>											
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5, 1951</u> , to <u>March 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 12, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Imre Neubaum M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 15,</u>					
22d. PHYSICIAN'S NAME (Type) <u>IMRE NEUBAUER</u>				22e. ADDRESS <u>936 Patuxent Ave</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/19/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MICHAEL'S CEMETERY</u>		23d. LOCATION (City or Town) <u>Glenn Burnie</u> (State) <u>MD.</u>					
24. FUNERAL DIRECTOR <u>Robert P. Ware</u>				ADDRESS <u>Singleton Funeral Home - Glenn Burnie Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Orlando Cude</u>			

0388

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

03312

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film 411 4/2/69 kk

CERTIFICATE OF DEATH

03307

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fort Smallwood		c. LENGTH OF STAY IN lb Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7108 Fort Smallwood Road 21226		d. STREET ADDRESS 7108 Fort Smallwood Road 21226	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Theodore Middle Edward Last Hohman		4. DATE OF DEATH Month March Day 24 Year 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 28, 1906
9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR Months 1 Days 24 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Continental Oil Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Hohman		14. MOTHER'S MAIDEN NAME Annie Schline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 21226	
17. INFORMANT Mrs. Florence M. Hohman		Address 7108 Fort Smallwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease DUE TO (b) marked coronary atherosclerosis DUE TO (c) Post coronary hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1967 to March 4, 1969 that (I) (we) last saw the deceased alive on Mar 5 1969 , and that death occurred at 4:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Samuel Rubin		22b. DATE SIGNED 3/20/69	
22c. PHYSICIAN'S NAME (Type) SAMUEL RUBIN M.D.		22d. ADDRESS 203 Patapsco Lane Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/28/69	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk		23d. LOCATION (City or Town) (County) (State) Howard Co. Maryland	
24. FUNERAL DIRECTOR McCully F. H.		25a. REC'D BY REGISTRAR 237 Patapsco Ave. 21225	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. MAR 26 1969	

08319

COMMITTEE OF DEATH

1-10-1944

1-10-1944

1-10-1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03313

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03308

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Margaret Marion Hopkins						Month	Day	Year	11:59		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White		15 October 1891			77 YRS.		MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		USA				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Ferndale, Glen Burnie			203 Hollins Ferry Road			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.			AA		Glen Burnie			203 Hollins Ferry Rd.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Earl B. Bentz, Sr.						Mary M. Cooksey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no						Mrs. Mildred Sturm, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Rupture of Abdominal Aneurysm										2 wks	
441.2 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										11 yrs	
(b) Marked Arterio Sclerosis and											
DUE TO, OR AS A CONSEQUENCE OF										11 yrs	
(c) Hypertension											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
old cerebral vascular accident											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>2 weeks</u> , 19 <u>58</u> , to <u>March 27</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 27</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					22c. DATE SIGNED						
<u>E. R. Shipley MD.</u>					25 Mar. 69						
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
E. R. Shipley, Md D.					529 S. Camp Meade Rd., Linthicum, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		26 Mar. 69		Friendship Cemetery		Linthicum, AA				Md.	
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Kirkley Funeral Home, Glen Burnie, Md.					MAR 26 1969		<u>Charles Judge</u>				

3120

ST. JOSEPH, MISSOURI, FEBRUARY 18, 1890

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03314		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03309	
Item No. Film 410 3/27/69 kk		CERTIFICATE OF DEATH			
1. DECEASED NAME (Type or print) First Middle Last James Maden HORN			2a. DATE OF DEATH Month Day Year March 17 1969		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 9, 1891	
6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Anne Arundel		10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gen. Hospital	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SHEET METAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTING		13a. STREET AND NUMBER Rt-4, Box 76	
13b. CITY OR TOWN Annapolis		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER Rt-4, Box 76	
14. FATHER'S NAME First Middle Last WILLIAM A. HORN		15. MOTHER'S MAIDEN NAME First Middle Last SARAH P. HICKEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No	
16b. SOCIAL SECURITY NO. 214-18-1793		17. INFORMANT John W. Fenton - 6014 Northwood Drive #12		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic cardiac failure DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks 2 yrs 10 yrs plus			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 1965 , to 3-17-1969 , that (I) (we) last saw the deceased alive on 3-17-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bertrand C. R. Gau M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 3-18-69					
22d. PHYSICIAN'S NAME (Type) Bertrand C. R. Gau, M.D.		22e. ADDRESS Rt-4, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-21-69		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Foley-Cronough F.H. - Catonsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 24 1969	
25b. REGISTRAR'S SIGNATURE William Judge					

3150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03315

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03310

1. DECEASED NAME (Type or print) <i>Guth Caroline Humiston</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>69</i>			2b. HOUR <i>3:4</i> M			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2-16-1889</i>		6. AGE (In years last birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>AA</i> Md.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A.A. Seaver Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>school teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>school</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>23 Kimberly Ct.</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>Thewer</i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Carrie</i> Middle <i>Raible</i> Last <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Homer A. Humiston, Arnold, Md.</i> Address <i></i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>acute myocardial infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>H.S.V.D.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , 19 <i></i> , to <i>1969</i> , 19 <i></i> , that (I) (we) last saw the deceased alive on <i>3-18-69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.									
22b. SIGNATURE <i>Robert Hahn</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>3-18-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT HAHN</i>					22e. ADDRESS <i>SEVERNA PARK, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/18/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D-C</i>			
24. FUNERAL DIRECTOR <i>Robert S. Banerjee, Severna Park, Md.</i> ADDRESS					25a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>MAR 20 1969</i>		25b. REGISTRAR'S SIGNATURE		

03312

03312

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03316

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03311

1. DECEASED-NAME (Type or Print) <i>James</i>			First Middle Last <i>Hutton</i>			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>3-14-69</i>			2b. HOUR <i>M</i>				
3. SEX <i>Male</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH <i>2-18-1899</i>		6. AGE (In years last birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>MD</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Ch. A.</i>				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Ch. General</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Retired</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>Ch. A. Churchton</i>				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>Ben Hutton</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Emma Hutton</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <i>Clarence Hutton Churchton</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis CVD</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>E. L. Hubbard</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>3-14-69</i>					
EXAMINER'S NAME (Type) <i>E. L. Hubbard</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>3-18-1969</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Hutton</i>					
24. FUNERAL DIRECTOR <i>William Reese H. Anna, MD</i>				ADDRESS				25a. REC'D BY REGISTRAR <i>Charles Judge</i>					
				25b. REGISTRAR'S SIGNATURE									

08310

08310

08310

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
04854												
1. DECEASED-NAME (Type or print)			First Arie			Middle Iverson#10808			Lost			
2. DATE OF DEATH			Month 3			Day 22			Year 69			
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 1880			6. AGE (In years last birthday) 88 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unkn.			12b. KIND OF BUSINESS OR INDUSTRY ----			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Balt. City			13c. CITY OR TOWN Balt.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER 822 N. Durham St.			14. FATHER'S NAME First Unkn.			15. MOTHER'S MAIDEN NAME First Unkn.			Middle Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 219-54-35971			17. INFORMANT Hospital Records				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a. DATE OF OPERATION -----			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u>Month</u> Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -----						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ---			21f. LOCATION Street or R.F.D. No. City or Town County State -----						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>47</u> , to <u>3/22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Charles R. Venter M.D.</u>			22c. DATE SIGNED 3/24/69			22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M. D.			22e. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>21422-69</u>			23b. DATE <u>4/22/69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Med. Md. School Baltimore Md.</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR APR 24 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03312		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03312					
Item #1, Film G411 4/7/69 km						CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
John		William		Jefferies		March 30		1969		2:45 M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.	
male		white		12-26-1886		82 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U. S. A.				Anne Arundel County				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
90 Glen Burnie		North Annapolis Convalescent Center		Salesman		Bakery					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		—		Baltimore				404 Annabel Ave.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Albert Jefferies								Charlotte Meseke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
None				Mrs. Clara M. Jefferies		404 Annabel Ave.				21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Diabetes mellitus, severe cerebral sclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (we) attended the deceased from 1/6/69, 19__, to 3/29/69, 19__, that (I) (we) last saw the deceased alive on 3/29/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Samuel Rubin, M.D.		203 E. Patapsco Avenue Baltimore, Md. 21225									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4/2/69		Cedar Hill		Ritchie Highway A. A. Co. Md.					
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
McCully F. H.		237 Patapsco Ave. 21225				APR 2 1969					

08316

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03319

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03313

1. DECEASED-NAME (Type or Print) <i>Pauline Johnson</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>3-16 1969</i>			2b. HOUR <i>M</i>		
3. SEX <i>Female</i>	4. RACE <i>Col</i>	5. DATE OF BIRTH <i>4-9-1903</i>	6. AGE in years (on birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>16</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Ch. A.</i>		
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>C. A. General</i>		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Ch. A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>62 Spa Road</i>
14. FATHER'S NAME <i>Arthur Davis</i>			15. MOTHER'S MAIDEN NAME <i>Louise A. Bowie</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT <i>George Johnson</i>			ADDRESS <i>Annapolis</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>514X Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Stroke</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>E. L. Linhart</i>			M.D.			22b. DATE SIGNED <i>3/16/69</i>		
EXAMINER'S NAME (Type) <i>E. L. Linhart</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>Annapolis</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-19-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION (City or Town) <i>Annapolis</i>		(County) <i>Md.</i>
24. FUNERAL DIRECTOR <i>William Beesett</i>			ADDRESS <i>Annapolis</i>			25a. REC'D BY REGISTRAR <i>MAR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

08810

RECORD EXAMINER - BUREAU OF DEATH

DEATH FOR
RECORD



DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03320										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03314														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																		
1. DECEASED-NAME (Type or Print) <u>John W. Johnston</u>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>3</u> Day <u>28</u> Year <u>1969</u>										2b. HOUR <u>10</u> M <u>P</u>														
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>9-23-1919</u>		6. AGE (In years last birthday) <u>49</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>		2c. DATE PRONOUNCED DEAD Month <u>3</u> Day <u>28</u> Year <u>1969</u>										2d. HOUR <u>10</u> M <u>P</u>												
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>					7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <u>P.A. 20</u>										Md.									
10. CITY OR TOWN OF DEATH <u>A.B.C.B.</u>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1001 North Arundel</u>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Machinist</u>					12b. KIND OF BUSINESS OR INDUSTRY <u>Tool & Die</u>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>					13b. COUNTY <u>Anne Arundel</u>					13c. CITY OR TOWN <u>Magothy Bch</u>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <u>Rte. 5, Box 193</u>														
14. FATHER'S NAME First <u>Joseph</u> Middle <u>Johnston</u> Last <u> </u>										15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle <u>Belsford</u> Last <u> </u>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					(If yes give war or dates of service) <u>WW II</u>					16b. SOCIAL SECURITY NO. <u>217-18-1186</u>					17. INFORMANT <u>Mrs. Dorothy M. Johnston</u>					ADDRESS <u>Same</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>429.9</u> IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a. DATE OF OPERATION <u> </u>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u>					21b. TIME OF INJURY Month, Day, Year <u> </u> HOUR A.M. <u> </u> P.M. <u>19</u>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u>																								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u>					21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>																								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																		
ACTUAL SIGNATURE <u>E. Linhardt</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED <u>3/28/69</u>														
EXAMINER'S NAME (Type) <u>E. Linhardt</u>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county) <u> </u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE <u>4-1-69</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>					23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u> </u>																			
24. FUNERAL DIRECTOR <u>George J. Gonce</u>										ADDRESS <u>4001 Ritchie Hwy. 21225</u>										25a. REC'D BY REGISTRAR <u>APR 7 1969</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Clifford Loehr JONES					2a. DATE OF DEATH Month March Day 8 Year 1969			2b. HOUR 9:00 MIN M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 4, 1908		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LIFE LBS.		12b. KIND OF BUSINESS OR INDUSTRY RA.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 602 State St.,	
14. FATHER'S NAME First Josiah H Middle JONES Last JONES				15. MOTHER'S MAIDEN NAME First ANNE Middle LOEHR Last LOEHR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) YES WW II		16b. SOCIAL SECURITY NO.		17. INFORMANT KATHERINE T. JONES #13 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 d 6 d 12 yr.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1956 to 3-8-69 , that (I) (we) last saw the deceased alive on 3-8-69 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE F. M. SHIPLEY MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-10-69			
22d. PHYSICIAN'S NAME (Type) F. M. SHIPLEY				22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-11-69		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or Town) (County) (State) Annapolis P.A. MD.			
24. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE John M. Taylor			

3657

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03322										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03316	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED-NAME (Type or Print)				First FRANCES				Middle L.				Last JONES				2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> March 17, 1969				2b. HOUR 7:30A	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 4/27/1935		6. AGE (In years last birthday) 33 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month March 17, Year 1969				2d. HOUR 7:30 AM					
7a. BIRTHPLACE (State or foreign country) Anne Arundel				7b. CITIZEN OF WHAT COUNTRY? USA.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Anne Arundel				Md.					
10. CITY OR TOWN OF DEATH Drury				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 140				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary				12b. KIND OF BUSINESS OR INDUSTRY State									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Anne Arundel				13c. CITY OR TOWN Drury				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 140							
14. FATHER'S NAME First Milton				Middle Evans				Last Mary				15. MOTHER'S MAIDEN NAME First Mary				Middle Virginia				Last Owens	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT Mary V. Evans				ADDRESS Drury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of head 965X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:00 AM March 17, 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject shot by husband													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. Box 140				City or Town Drury				County A.A.		State M.D.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Ronald N. Kornblum				M.D. Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/17/69									
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3/22/69				23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery				23d. LOCATION (City or Town) (County) (State) Bristol, Maryland									
24. FUNERAL DIRECTOR Stewart				ADDRESS Funeral Home-4001 Benning Road				25a. REC'D BY REGISTRAR DATE MAR 24 1969				25b. REGISTRAR'S SIGNATURE Charles J. Jones									

92380

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250 V

100 100

NAME

443 0405 3927

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03323		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03317	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
John Wesley JONES						Month	Day
						Year	2b. HOUR
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)
Male			Negro		May 1, 1911		57 YRS.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
Maryland			U.S.				Anne Arundel Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Annapolis			Anne Arundel Gen. Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland			Anne Arundel		Crownsville		13e. STREET AND NUMBER
							Box 17
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
First			First		Middle		
Theodore			Louise		Pindell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
					William Jones, Waterbury, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							6 months
IMMEDIATE CAUSE (a) Congestive heart failure							
4124 DUE TO, OR AS A CONSEQUENCE OF							many
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							years
(b) Arteriosclerotic cardiovascular disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c) - - - - -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
None - - - - -							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None		NA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) did not attended the deceased from March 2, 1969, to March 7, 1969, that (I) did not saw the deceased alive on March 6, 1969, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Charles W. Kinzer				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		March 7, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Charles W. Kinzer, M. D.				16 Murray Ave., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-10-1969		Mt. Tabor		Chesterfield Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William Reese, Annapolis, Md.				DATE		MAR 10 1969	

FSC® C01474

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03324		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03318									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED-NAME (Type or Print)				First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED				2b. HOUR							
THOMAS				M.				JONES		March 17, 1969				7:30A							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		2c. DATE PRONOUNCED DEAD Month		2d. HOUR							
Male		Negro		3/7/1934		35 YRS.						March 17, 1969		7:30A							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Anne Arundel				M.D.						Anne Arundel											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY									
Drury				Box 140 Drury				Cement truck driver													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland				Anne Arundel				Drury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 140									
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last			
Thomas								Jones		Marjorie								Sellman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT										ADDRESS			
(If yes give war or dates of service)								Marjorie Jones										Drury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Gunshot wound of head																					
955X DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (head-only)													
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 17, 1969 12:00XXX March 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Self-inflicted gunshot wound of head													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State Rte. 140 Drury A.A. M.D.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE				Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 3/17/69									
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				3/22/69		Moses Cemetery				Bristol, Maryland											
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
Stewart				MAR 24 1969				John T. Stewart													
Funeral Home-4001 Benning Road, N.E.																					

08888

UNITED STATES DEPARTMENT OF AGRICULTURE

STATE OF NEW YORK

IN SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03325					03319					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last					Month Day Year			PM		
Willie James Joyner					3/21/69			6:45		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Negro		6/29/48		20 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
North Carolina		USA				Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Laurel			D. C. Children's Center			Institutionalized				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Washington, D. C.									1215 6th St., N.W.	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Charlie Mack Joyner					Mattie Lee Perkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		D. C. Children's Center Hospital, Laurel, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Bronchopneumonia LUL</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pseudohypertrophic Muscular dystrophy</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION			19b. CONOITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from <u>6/10/</u> , 19 <u>65</u> , to <u>3/21/</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>3/21/69</u> , 19 <u>69</u> , and that in (my) (our) apinian death occurred on the date and haur and from the causes stated obave, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Margaret Mola, M.D.									3/21/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Margaret Mola, M.D.					D. C. Children's Center Hospital, Laurel, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-27-69		Children's Center		Laurel, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Danaedean Funeral Home Laurel, Md.					APR 1 1969		Charles Judge			

03332

DEPARTMENT OF HEALTH

James Mack Johnson
Male
White
6/20/43
20
James Mack Johnson
D. C. Children's Center Institutionalized
1215 6th St., N.W.
Washington, D. C.

James Mack Johnson
Male
White
6/20/43
20
James Mack Johnson
D. C. Children's Center Hospital
Laurel, Md.

James Mack Johnson
Male
White
6/20/43
20
James Mack Johnson
D. C. Children's Center Hospital
Laurel, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
03326 CERTIFICATE OF DEATH 03320																				
1. DECEASED-NAME (Type or print) JOANN (ANNA)						First			Middle			Last			2a. DATE OF DEATH Month 3 Day 25 Year 69			2b. HOUR M		
3. SEX Female				4. RACE White				5. DATE OF BIRTH 5/1/196				6. AGE (In years last birthday) 72 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Greece				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ANNE ARUNDEL County Md.								
10. CITY OR TOWN OF DEATH Glen Burnie, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Convalescent Center				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY —								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY Balto.				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8026 E. BANK STREET.						
14. FATHER'S NAME First Paul Middle Last						15. MOTHER'S MAIDEN NAME First Mary Middle Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. —				17. INFORMANT Paul Kataculos, 8026 E. Bank St. Baltimore, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CKA 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) ASCUD DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Nicholas T. Matthews DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 3/27/69				23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.								
24. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md.						25a. REC'D BY REGISTRAR MAR 28 1969				25b. REGISTRAR'S SIGNATURE Nicholas Judge										

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

038350

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1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03327		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03321		
Item #1 Film G 422		CERTIFICATE OF DEATH				
1. DECEASED-NAME (Type or print)		First AKA Rose	Middle	Last	2a. DATE OF DEATH 3 Month 12 Day 69 Year	2b. HOUR 6:35a M
Rosella		M.		Katoski		
3. SEX White Female	4. RACE White	5. DATE OF BIRTH January 1, 1905		6. AGE (In years last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tavern Owner		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rt. 1, Box 157 Nabbs Creek Rd.		
14. FATHER'S NAME First Middle Last Murdoch MacKay	15. MOTHER'S MAIDEN NAME First Middle Last Barbara White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 217-22-2206	17. INFORMANT Donald Katoski			Address Route 1 Box 227 Glen Burnie, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS HD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Recent Surgery for Diverticulitis Signed -</u>						
19a. DATE OF OPERATION 3/3/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/13/69, 19__, to 3/12/69, 19__, that (I) (we) lost saw the deceased alive on 3/11/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Jorge Ramirez M.D.		22c. DATE SIGNED 3/12/69		22d. PHYSICIAN'S NAME (Type) JORGE RAMIREZ, M. D.		
22e. ADDRESS 325 Hospital Drive, Glen Burnie, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3/15/69	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Anne Arundel, Maryland		
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue		25a. REG'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE J. J. Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03328
Susan

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03322

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Susan			First Middle Last			2a. DATE OF DEATH Month 22 Day 1969 Year			2b. HOUR 11 A. M.		
3. SEX FEmale			4. RACE White			5. DATE OF BIRTH 9/29/89			6. AGE (in years last birthday) 79 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Co. Md.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own- Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last (unknown) Zell			15. MOTHER'S MAIDEN NAME First Middle Last (unknown)			13e. STREET AND NUMBER Riverside Dr. Magothy Beach					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 216-01-7253-B			17. INFORMANT Address Mr. Alfred H. Kerbe (husband) # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 4121 DUE TO, OR AS A CONSEQUENCE OF ASHD - Circulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. General debility (b) General debility DUE TO, OR AS A CONSEQUENCE OF (c) General debility									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Obesity, Hypertension											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-21-1969 to 3-22-1969 , that (I) (we) lost the deceased alive on 3-21-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Dorkan			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-22-69		
22d. PHYSICIAN'S NAME (Type) Cenap S. DORKAN, MD			22e. ADDRESS 325 Hospital Drive, Glen Burnie, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 26, 1969			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland		
24. FUNERAL DIRECTOR EB Fleming			ADDRESS Singleton Funeral Home Glen Burnie, Md.			25a. REC'D BY REGISTRAR MAR 26 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03329										03323									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First <i>Mildred</i>			Middle <i>McCullough</i>			Last <i>KIBLER</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>M</i>				
3. SEX <i>female</i>			4. RACE <i>white</i>			5. DATE OF BIRTH <i>Sept. 17, 1895</i>			6. AGE (In years last birthday) <i>73</i> YRS.			IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>15</i>			IF UNDER 24 HRS. HOURS <i>15</i> MIN.				
7a. BIRTHPLACE (State or foreign country) <i>Illinois</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Anne Arundel</i> Md.										
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Annapolis Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales Representative</i>			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>10b</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>4418 Marble Hall Road</i>							
14. FATHER'S NAME First <i>Ellsworth</i>			Middle <i>W.</i>			Last <i>McCullough</i>			15. MOTHER'S MAIDEN NAME First <i>Clara</i>			Middle <i>Moore</i>			Last <i>Moore</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>218-32-3492</i>			17. INFORMANT Address <i>Mrs. Frank Shipley Rt#2 Annapolis Md. 21401</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4329</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brain Stem infarction due to</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>occlusion of l. vertebral artery</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>4 mos</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <i>11-1-1969</i> , to <i>3-6-1969</i> , that (I) (we) last saw the deceased alive on <i>3-2-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>Frank M. Shipley MD</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>3-6-69</i>										
22d. PHYSICIAN'S NAME (Type) <i>F. M. SHIPLEY</i>			22e. ADDRESS <i>Annapolis, Md</i>																
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>3/10/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>			23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>										
24. FUNERAL DIRECTOR ADDRESS <i>Mitchell-Wiedefeld Home 6500 York Rd. Balto. Md.</i>			25a. REC'D BY REGISTRAR DATE <i>MAR 11 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>													

Memorandum

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03330										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03324			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR			
First Middle Last										Month Day Year										2b. HOUR			
John Anthony Klein										3 3 69										8:a M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS								
Male			Negro- White			6/16/30			38 YRS.			MONTHS DAYS HOURS MIN											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH														
Washington			US						Anne Arundel						Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY														
Crownsville			Crownsville State Hospital			Equipment Operator																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER											
Maryland			AA			West River						Box 4582 Cherry Point Rd.											
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																				
First Middle Last			First Middle Last																				
John W. Klein			Cecilia Ofenstein																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT																	
			213 36 5824			Hospital Records, Crownsville State Hospital																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Severe acute pulmonary edema and congestion																							
3032 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) Focal bronchopneumonia, basal																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) Chronic alcoholism.																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
Malnutrition; acute esophagitis																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
			HOUR A.M. Month Day Year P.M. 19																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 69, to 3/3, 19 69, that (I) (we) lost saw the deceased alive on 3/3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE			22c. DATE SIGNED																				
Charles R. Venturo			3/5/69																				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																				
			Crownsville State Hospital, Maryland																				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)														
Burial			3/7/69			Parklawn Cem.			Rockville, Md.														
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
Nalley's Funeral Home Inc.			MAR 11 1969			f. m. m. judge																	

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03331

CERTIFICATE OF DEATH

03326

1. DECEASED-NAME (Type or print) ELIZABETH A			First Middle Last			2a. DATE OF DEATH Month Day Year MARCH 25 1969			2b. HOUR 8 A M		
3. SEX Female			4. RACE white			5. DATE OF BIRTH 7/3/78			6. AGE (In years last birthday) 90 YRS.		
7a. BIRTHPLACE (State or foreign country) md			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Annapolis Convalescent			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY AA			13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 23 FRANCIS St.			14. FATHER'S NAME First Middle Last Michael Levi			15. MOTHER'S MAIDEN NAME First Middle Last Mary Morawitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-48-8436			17. INFORMANT George Woelfel Annapolis Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Insufficiency 4379 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/11, 1966 , to 3/25, 1969 , that (I) (we) lost saw the deceased alive on 3/19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard L. Macleany md						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/25/69		
22d. PHYSICIAN'S NAME (Type) 16 Murray Avenue						22e. ADDRESS Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/27/69			23c. NAME OF CEMETERY OR CREMATORY St Marys			23d. LOCATION (City or Town) (County) (State) Annapolis AA Md		
24. FUNERAL DIRECTOR Thomas A. Hardesty Annapolis Md						25a. REC'D BY REGISTRAR MAR 27 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03331

CERTIFICATE OF DEATH

STATE OF NEW YORK

1933

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03332											
03327											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First George Middle H. Last Kramer#29265			2a. DATE OF DEATH Month 3 Day 23 Year 69		2b. HOUR 8:10 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7/17/99		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unkn.		12b. KIND OF BUSINESS OR INDUSTRY -----					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6 S. Chester Avenue			
14. FATHER'S NAME First Charles Middle Kramer Last			15. MOTHER'S MAIDEN NAME First Bertha Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-05-7229T		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 1621 DUE TO, OR AS A CONSEQUENCE OF (1) Bronchogenic Ca Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (2) Pulmonary Emphysema (3) Cachexia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION --		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -----							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) -----		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/8, 1965, to 3/23, 1969, that (I) (we) last saw the deceased alive on 3/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Gonzalez, M. D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/24/69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/25/1969		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City or Town) (County) (State) BALTIMORE, Md					
24. FUNERAL DIRECTOR Le. Brooke Bradley, Headlark, Md				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03333

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03333

CERTIFICATE OF DEATH

03328

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>900 N. DALLAS ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1969</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-03</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Norfolk, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Balls</u>		14. MOTHER'S MAIDEN NAME <u>Helen Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ethel Myers</u>		Address <u>1512 Mulligan St. Md Baltimore</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>4122</u> DUE TO (b) <u>Cerebro Vascular Accident</u> DUE TO (c) <u>Hypertensive Cardio-vascular Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis; Alcoholism; Obesity; Umbilical Hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>2/24/1969</u> to <u>3/15/1969</u> that (I) (we) last saw the deceased alive on <u>3/15/1969</u> , and that death occurred at <u>5:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>		22b. DATE SIGNED <u>3/15/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/19/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR <u>Joseph M. Locks Jr.</u>		25a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>1304 N. Central Ave Balt.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>MAR 19 1969</u>			

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11-1-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-59

03334

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03329

1. DECEASED-NAME (Type or print) <i>Mathias F.</i>		First	Middle	Last	2a. DATE OF DEATH <i>3</i> Month <i>15</i> Day <i>69</i> Year		2b. HOUR <i>9:25</i> M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/22/'85</i>		6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nursing Conv.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Printing business</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7437 Stonewood Rd.</i>	
14. FATHER'S NAME <i>Unknown</i>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Unknown</i>		First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Wardour, Annapolis, Md.</i> <i>Mr. Eugene E. Leimkuhler 7 Sherwood Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro vascular Accident (Rt)</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>(Atherosclerosis)</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>Years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Decubitus/Previous CVA/Gastroenteritis/Pulm. Cavities - Ca??</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Summer, 1967</i> , to <i>Present</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-15</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph F. Vukobratovic</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/15/69</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/18/'69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Baltimore St.</i>				25a. RECEIVED BY REGISTRAR <i>MAR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

03332

03332

EXHIBIT OF DATA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03335		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03330	
Items#2a,22a,FilmG411 4/7/69 km							
1. DECEASED-NAME (Type or print) First Middle Last Everett William LE MASTER				2a. DATE OF DEATH Month Day Year March 24 1969		2b. HOUR 9:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 25, 1914		6. AGE (In years last birthday) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County, Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) owner		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		13e. STREET AND NUMBER Box 94 B, Rt. 5			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 213056230		17. INFORMANT Lillian L. Master - Above Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA, RECTUM 2 years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 3/13/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 3/23/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Jesse L. Wilkins M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.		22e. ADDRESS 98 CATH. ST., ANNAPOLIS, M.D.		22c. DATE SIGNED 3/24/69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY Green Haven Cem.		23d. LOCATION (City or Town) (County) (State) Green Haven A.D. Ind	
24. FUNERAL DIRECTOR Robert S. Baranco		ADDRESS Severna Park, Ind		25. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE William J. Jones	

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FOR STATE
HEALTH DEPT.

03336

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03331

1. DECEASED-NAME (Type or Print) Mary		First		Middle		Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month March Day 23 Year 1969		2b. HOUR 2:50 a <input type="checkbox"/> M <input type="checkbox"/>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1/4/10		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) Wilmington N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County		2c. DATE PRONOUNCED DEAD Month 3 Day 23 Year 1969		2d. HOUR 2:50 a <input type="checkbox"/> M <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own-Home		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N. C.		13b. COUNTY New Hanover	
13c. CITY OR TOWN Wilmington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 118 Dogwood Dr.		14. FATHER'S NAME First Unknown Middle Hines Last (unknown)		15. MOTHER'S MAIDEN NAME First (unknown) Middle (unknown) Last (unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None	
16b. SOCIAL SECURITY NO. 242-40-6134		17. INFORMANT Mrs. Grace C. Strand (daughter)		ADDRESS 8002 Phirne Rd. Glen Burnie		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Has had a cerebral hemorrhage in the past		19a. DATE OF OPERATION _____	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____		21b. TIME OF INJURY Month, Day, Year _____ HOUR A.M. _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No injury		21d. INJURY OCCURRED WHEN <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		22b. DATE SIGNED 3/23/69		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22d. ADDRESS (Street, city, town, or county) _____		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Memorial Pk.		23d. LOCATION (City or Town) Wilmington, N.C. (County) _____ (State) _____		24. FUNERAL DIRECTOR E.B. Fleming ADDRESS Glen Burnie, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 26 1969		25d. DATE MAR 26 1969		25e. DATE MAR 26 1969		25f. DATE MAR 26 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE: March 25, 1954

TIME: 11:10 AM

PLACE OF DEATH: Home of Coroner

NAME: John Smith

AGE: 45

SEX: Male

CAUSE OF DEATH: Myocardial Infarction

MANNER OF DEATH: Natural

Signature of Medical Examiner

Signature of Coroner

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

Signature of Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03337												
03332												
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR				
First Alfred					Middle Leroy			Last Martin				
3. SEX Male			4. RACE White			5. DATE OF BIRTH 10-16-87			6. AGE (In years lost birthday) 81 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH A.A.Co.			
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Optometrist			12b. KIND OF BUSINESS OR INDUSTRY Optician			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) Maryland			13b. COUNTY A.A.Co.			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First John			Middle L.			Last Martin			15. MOTHER'S MAIDEN NAME First Sarah			
Middle C.			Last Burnett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. W. W. 1			
17. INFORMANT Mrs. May E. Martin			Address 106 Granada Road 21122									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1968 , 19____, to 3/2/69 , that (I) (we) lost saw the deceased alive on 3/6/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE George B. Ramirez M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS 325 Hospital Dr Suite 207 Glen Burnie Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR McCallister						ADDRESS 237 Patapsco Ave. 21225			25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Johns Judge	

08332

RECEIVED

1953

11-10-53

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03338

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03333

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Harold Snyder McClure			2a. DATE OF DEATH Month Day Year March 5 1969			2b. HOUR M 1					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 18, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (State or foreign country) Dunkard, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Annapolis Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Welder (Ret)			12b. KIND OF BUSINESS OR INDUSTRY Martin Air.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 47 Farragut Road		
14. FATHER'S NAME First Middle Last William W. McClure			15. MOTHER'S MAIDEN NAME First Middle Last Della Snyder								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 171/18/6843A		17. INFORMANT Address Mrs. Ilene M. Pappafotis Glen Burnie, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1968 to 3/5, 1969 , that (I) (we) last saw the deceased alive on 2/24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard I. Hochman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3/5/69						
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.					22e. ADDRESS 16 Murray Avenue Annapolis, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 8, 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.				
24. FUNERAL DIRECTOR ADDRESS R.V. Singleton, Glen Burnie, Md.					25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

03338

RECEIVED OF REVENUE

1911 5 March 1911

1911 5 March 1911

1911 5 March 1911

1911 5 March 1911

1911 5 March 1911

1911 5 March 1911

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03339

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03334

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH				2b. HOUR	
Richard			S		McCullough	<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 3 15 69				6 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	3/20/04	64 YRS	MONTHS	DAYS	HOURS	MIN.	Month 3 Day 15 Year 1969	A M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel Co		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		PCA-NORTH ARUNDEL-		Carpenter		Construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		A. A.		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 137			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Henry					McCullough	Isabelle E.					Hinberger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			218-09-0391			R.S. McCullough, Jr.			Box 181, Crownsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arterio-sclerotic C.V.D.</u>											
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH			HOUR A.M. P.M.		19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER			3/15/69					
E. Linhardt M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			A.A.C.O.					
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		3/15/69		Epiphany Episcopal Cem			Odenton A.A. Md				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Dorothy E. Hopping				Hopping Funeral Home, Annapolis, Md.				MAR 18 1969		Charles Vande	

03839

STATE OF
NEW YORK

1915

IN SENATE
JANUARY 15, 1915

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03340 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #13a, Film Gull 4/16/69

03335

1. DECEASED-NAME (Type or Print) Ernest Albert McDowell			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 31 Year 69			2b. HOUR P
3. SEX M	4. RACE W	5. DATE OF BIRTH 10/9/03	6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 3 Day 31 Year 69
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? England		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DM-North Anndel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Master Sadler (ret.)		12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE England		13b. COUNTY Essex		13c. CITY OR TOWN Halstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER #15 Pretoria Road						
14. FATHER'S NAME First Ernest Middle McDowell Last Ada			15. MOTHER'S MAIDEN NAME First Ada Middle Ranger Last Ranger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Christina McDowell (wife) Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4299 DUE TO, OR AS A CONSEQUENCE OF Cardiac Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CHARTER (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE E. L. in hand		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/31/69 APRO
ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE April 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR R. V. Singleton		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...
Glen Burnie, Maryland						

0360

498 3 294

03341

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Mary		G.		Melgaard	Month 3 Day 3 Year 1969		10:45 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female	White		3 July 1884		84 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		USA				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Severna Park		423 Ben Oaks Drive		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		AA		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		423 Ben Oaks Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Hamilton		McCann		Alicia Vance					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		216-46-6001		Mrs. Alicia Melgaard, 423 West Ben Oaks, Severna Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive heart failure								1 month	
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) Atherosclerotic CVD									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Dec 28, 1968, to March 3, 1969, that (I) (we) last saw the deceased alive on Feb. 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Herbert J. Levickas				MD				3/3/69	
22d. PHYSICIAN'S NAME (Type) Dr. Herbert J. Levickas				22e. ADDRESS					
				5404 East Drive, Baltimore, Md. 21227					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		5 March 69		Loudon Park Cemetery		Baltimore Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Kirkley Funeral Home, Glen Burnie, Md. 21061				DATE MAR 5 1969		J. C. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08341

INSTITUTE OF HEALTH

NAME: [illegible] SEX: [illegible] AGE: [illegible]

DATE: [illegible] TIME: [illegible]

LOCATION: [illegible] ROOM: [illegible]

TEST: [illegible] RESULT: [illegible]

ANALYST: [illegible] REVIEWER: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

ROOM: [illegible]

TEST: [illegible]

RESULT: [illegible]

ANALYST: [illegible]

REVIEWER: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

03342

03337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR		
Lawton			Berkley	Mellichampe	20. DATE ESTIMATED				3	17	69	P	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				Month	Day	Year	2d. HOUR
M	W	6-16-05	63	MONTHS		DAYS		3				17	69	P	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
North Carolina		USA		WIDOWED		DIVORCED		AA CO							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			AA General			Salesman			Real estate						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
MD			AA			Edgewater			YES			NO			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
WINBORN L. Mellichampe			AMELIA JONES HOOPER												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
Yes			1944-46			577-09-8629			MARGARET MELlichAMPE			Edgewater, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Coronary Artery Disease C.V.C.</u>															
4124															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES							
21a. EXTERNAL CAUSE WAS PRIMARY				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
OR CONTRIBUTING CAUSE OF DEATH				19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.							
WHILE AT WORK								City or Town							
NOT WHILE AT WORK								County							
								State							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
								3-18-69							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)							
E. L. W. H. A. V. A.								AA CO.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
Cremation				3/18/69				Lee Crematory							
								23d. LOCATION (City or Town) (County) (State)							
								WASHINGTON DC							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR							
Hardisty Funeral Home, Gaithersburg, Md								DATE							
								MAR 26 1969							
								25b. REGISTRAR'S SIGNATURE							
								Charles Judge							

03880

HEALTH DEPT
FBI

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8 1
03343

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03338

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Elsie M. Miller			2a. DATE OF DEATH Month Day Year 3 8 69			2b. HOUR P M 1:50	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 4-26-98		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Joseph Milligan		15. MOTHER'S MAIDEN NAME First Middle Last Etta R. XXXXX Thomas		13e. STREET AND NUMBER 244-A, Bodkin Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-03-3206		17. INFORMANT Address Mrs. Irvin Anderson, 8382 Carroll Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> 4123 DUE TO, OR AS A CONSEQUENCE OF <u>Chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>uracemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASHD</u> (c) <u>hypophosphatemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/5, 19 69, to 3/8, 19 69, that (I) (we) lost saw the deceased alive on 3/8, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benjamin DeGuzman		22c. DATE SIGNED 3/8/69		22d. ADDRESS 335 Hospital Dr. Glen Burnie, Md. 21061			
22d. PHYSICIAN'S NAME (Type) Benjamin DeGuzman		22e. ADDRESS		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-12-1969		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Md. Washington Blvd., Howard Co.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. RECEIVED BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE James J. Jones	

928200

3. 42

3

22

Figure 1

DOI: 10.1002/for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03344		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03339					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First		Middle		Last		Month		Day	Year	HRS.	
John		W.		Moll		March		5	1969	3:25A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		6-11-09		59 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna		U.S.A.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		North Arundel Hospital		heavy equip. operator		Civil Service					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Anne Arundel		Odenton				301 Nevada Avenue			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
yes		1930's		212-12-6470		Helen A. Moll - same as #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>HTN</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Chronic uricemia?</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/69</u> , 19 <u>69</u> , to <u>3/15/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/1/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)							
<u>Jorge B. Ramirez</u>		<u>3/15/69</u>		<u>Jorge B. Ramirez, M.D.</u>							
22e. ADDRESS		22f. ADDRESS									
		<u>325 Hospital Drive, Glen Burnie, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<u>Burial</u>		<u>3/7/69</u>		<u>Epiphany Episcopal Cem.</u>		<u>Odenton</u>		<u>A.A.</u>		<u>Md.</u>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
<u>Beverly E. Hopping</u>		<u>MAR 7 1969</u>		<u>Charles Judge</u>							
<u>HOPPING FUNERAL HOME - Annapolis, Md.</u>											

1989

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03340

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/> Month Day Year			2b. HOUR M	
CLARENCE			MORELAND						19	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR p. M
male	white	3 March 1936	33 YRS.					March 10, 1969		9:00 p. M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Anne Arundel County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			North Arundel Hospital			Dry Well Installer			Coast	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Gambrills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 229, Underwood Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Richard Moreland			Myrtle M. Dallas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS					
no			-----		212-34-8295 Richard Moreland (Father)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>8120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR <u>8:30</u> P.M. <u>3/10</u> 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>driver of pick up truck - went through stop sign - stuck a tractor trailer truck - broadside</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>street</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rte 3 & St. Stephens Church Road, Maryland</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Werner U. Spitz</u>			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>3/11/69</u>		
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		14 Mar. 1969		Glen Haven Memorial Pk.			Glen Burnie, Md.			
24. FUNERAL DIRECTOR Richard V. Singleton/Glen Burnie, Md.						25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03346

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03341

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last JOSEPH HORACE MORETZ			2a. DATE OF DEATH Month Day Year MARCH 28 1969			2b. HOUR I 720 PM					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 14 JUNE 1928		6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNA ARUNDAL			Md.		
10. CITY OR TOWN OF DEATH FT. GEO. G. MEADE, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KIMBROUGH ARMY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RESEARCH ANALYSIS I			12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ANNA ARUNDAL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 362 MAE ROAD			
14. FATHER'S NAME First Middle Last HORACE GRADY MORETZ			15. MOTHER'S MAIDEN NAME First Middle Last MATTIE MAE JOHNSTON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-22-9112		17. INFORMANT Address EVELYN MORETZ SAME AS ITEM 13a-13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE (SHOCK)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFRACTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8HRS 10HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>28 MAR</u> , 1969, to <u>28 MAR</u> , 1969, that (I) (we) lost saw the deceased alive on <u>28 March</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dennis L. Hemingway</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>28 MARCH 1969</u>				
22d. PHYSICIAN'S NAME (Type) DENNIS L. HEMINGWAY					22e. ADDRESS KIMBROUGH ARMY HOSP., FT. GEO. G. MEADE, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/1/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.			23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland				
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md. Robert P. Ware					25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Sledge</u>				

02850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03347

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03342

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last ALICE ELIZABETH MORTEN			2a. DATE OF DEATH Month Day Year March 9 1969		2b. HOUR A M 0500
3. SEX Female	4. RACE Negro		5. DATE OF BIRTH March 8, 1969		6. AGE (In years lost birthday) YRS. MONTHS DAYS 7 35
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.
10. CITY OR TOWN OF DEATH Ft. Geo G Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3410 Woodbine
14. FATHER'S NAME First Middle Last Harrison Joseph Morten			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Freeman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Harrison J. Morten, 3410 Woodbine Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apnea</u> <u>7700</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity & cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Placenta previa</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 Hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) this doctor attended the deceased from <u>8 March</u> , 19 <u>69</u> , to <u>9 March</u> , 19 <u>69</u> , that (I) was last saw the deceased alive on <u>9 March</u> , 19 <u>69</u> , and that in (my) your opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.					
22b. SIGNATURE <u>Herbert Spolter MD</u>				22c. DATE SIGNED 9 Mar 69	
22d. PHYSICIAN'S NAME (Type) HERBERT SPOLTER, CPT, MC				22e. ADDRESS Kimbrough Army Hospital Ft. Meade	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/13/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke, Ellicott, City, Md.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE MAR 14 1969	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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ALICE WILLIAMSON BATHEN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03348		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03343	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) CHRISTINE (Christina) A. NEWTON				2a. DATE OF DEATH 3 Month 10 Day Year 69		2b. HOUR 8:10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/22/13		6. AGE (In years last birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Nat'l. Plas	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Frank Middle J. Last Kuchta		15. MOTHER'S MAIDEN NAME First Mathilda Middle Hedl Last #13					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 212 05 7817		17. INFORMANT Mr. Raymond W. Newton (husband) Same as address Chart: North Arundel 301 Hospital Dr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan - , 19 66 , to 2/10 , 19 68 , that (I) (we) lost saw the deceased alive on 3/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles Judge DEGREE MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/10/69	
22d. PHYSICIAN'S NAME (Type) Abbas G. G. G. G.				22e. ADDRESS 1113 Odessa Rd Odessa 21113			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Rob't P. Ware		ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CHARTERED (1914-1915) A. HENRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03349										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03344									
1. DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										HOURS MIN.									
1. DECEASED-NAME Hugh T. O'Neill										2a. DATE OF DEATH Month 3 Day 7 Year 69										2b. HOUR 11:45									
3. SEX Male			4. RACE White			5. DATE OF BIRTH 25 April 1894			6. AGE (In years last birthday) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.																				
10. CITY OR TOWN OF DEATH Anne Arundel			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Knollwood Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Professor-university education			12b. KIND OF BUSINESS OR INDUSTRY Cath. faith																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 571 Coover Rd.																	
14. FATHER'S NAME First Middle Last Bryan I. O'Neill					15. MOTHER'S MAIDEN NAME First Middle Last Mary Kleckner																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown no					16b. SOCIAL SECURITY NO. 218-36-7700A					17. INFORMANT Raphael O'Neill					3105 Queens Chapel Rd. Apt. 202, Mt. Rainier, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1538 IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of colon															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 7, 1969, that (I) (we) last saw the deceased alive on March 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Charles W. Kinzer										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.										22e. ADDRESS 16 Murray Avenue, Annapolis, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/10/69			23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields			23d. LOCATION (City or Town) (County) (State) Millersville A.A. Md.																				
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.										25a. REC'D BY REGISTRAR DATE MAR 10 1969					25b. REGISTRAR'S SIGNATURE Charles Judge														

03042

CRIMINAL RECORD

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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MAR 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

03350		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03345					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Harry			First (none)		Middle ORME		2c. DATE OF DEATH Month March Day 14 Year 1969		2b. HOUR 12:10		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 27, 1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Real Estate		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 670 Americana Drive, Apt. 27		
14. FATHER'S NAME First HARRY Middle A. Last ORME			15. MOTHER'S MAIDEN NAME First THADDINIA Middle WOODSON Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579-09-0434		17. INFORMANT CORA V. ORME Address 670 Americana Dr. Annapolis, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure - 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Seal of the heart failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard N. Peeler, M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/19/69			
22d. PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.						22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3/17/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis AA Md				
24. FUNERAL DIRECTOR Hardesty Funeral Home, Annapolis, Md ADDRESS						25a. REC'D BY REGISTRAR DATE MAR 19 1969		25b. REGISTRAR'S SIGNATURE William J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03351

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03346

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Frank Parker			2a. DATE OF DEATH Month 3 - Day 15 - Year 1969			2b. HOUR 1030p M			
3. SEX Male		4. RACE Col		5. DATE OF BIRTH 5-12-1880		6. AGE (in years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ind.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A. A. Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 156 Best Gate Rd. Baltimore		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Ind.		13b. COUNTY A. A.		13c. CITY OR TOWN Annap.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 156 Best Gate Rd	
14. FATHER'S NAME First George W Middle parker Last parker			15. MOTHER'S MAIDEN NAME First Charabell Middle Addison Last Addison						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Ann Maria Parker Address Ind.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 303.2 IMMEDIATE CAUSE (a) malnutrition DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) possible pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/1 , 19 69 , to MARCH , 19 69 , that (I) (we) last saw the deceased alive on 3/1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. BERN					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/69
22d. PHYSICIAN'S NAME (Type) R. BERN M.D.					22e. ADDRESS 121 Calhoun St Annapolis				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-17-1969		23c. NAME OF CEMETERY OR CREMATORY Fowlers		23d. LOCATION (City or Town) (County) (State) Annapolis A. A. Md.			
24. FUNERAL DIRECTOR William Beeson					ADDRESS Annapolis Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge

08331

RECEIVED BY DEATH

08331

[Faint, mostly illegible handwritten text, possibly a list or notes.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-5
304 REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03352									
CERTIFICATE OF DEATH									
03347									
1. DECEASED-NAME (Type or print) <i>Tony</i>			First Middle Last <i>Patterson</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>4</i> Year <i>69</i>		2b. HOUR <i>5 P M</i>	
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>May 10, 1891</i>		6. AGE (In years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Antioch</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>PLAZA Manor Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Simpsonville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. # 29</i>	
14. FATHER'S NAME First Middle Last <i>Wash Patterson</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Antioch</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Antioch</i>		16b. SOCIAL SECURITY NO. <i>220-22-0132 A</i>		17. INFORMANT <i>C. F. Fawcett, Plaza Manor Nur. Home</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Epilepsy, Grand Mal (severe)</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 or 6 days</i> <i>unknown</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-19</i> , 19 <i>66</i> , to <i>2/28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/28</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Richard H. Hunt</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/4/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Richard H. Hunt</i>				22e. ADDRESS <i>100 Church Lane, Glen Burnie, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>MAR. 7, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Locust Church Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Simpsonville, Howard, Md</i>			
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				ADDRESS <i>Rockville Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

0000

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03353

CERTIFICATE OF DEATH

03348

1. DECEASED-NAME (Type or print) Joseph Henry PEDDICORD			2a. DATE OF DEATH Month March Day 22 Year 1969			2b. HOUR 12:30 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH January 7, 1913		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sewer Plant Operator		12b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland STATE		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 176 Acton Road	
14. FATHER'S NAME First Louis Middle Henry Last Peddlicord			15. MOTHER'S MAIDEN NAME First Sarah Middle Elizabeth Last Greenwell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-07-8001		17. INFORMANT Address Ruth L. Peddicord - same as #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest (standstill) 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic coronary heart disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes 33 months many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, Obesity, Chronic bronchitis, Varicose veins, (Psoriasis)									
19a. DATE OF OPERATION Feb 19, 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac catheterization		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 18, 1966 to March 22, 1969 , that (I) (we) saw the deceased alive on March 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles W. Kinzer		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 22, 1969			
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22e. ADDRESS 16 Murray Ave., Annapolis, Md. 21401							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, A.A. Md.			
24. FUNERAL DIRECTOR Beverly E. Hopping		ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE MAR 24 1969									

03353

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
JAN 10 1964
MEMORANDUM
TO : DIRECTOR
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, including a large circular stamp and various lines of text that are mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03354

03349

1. DECEASED-NAME (Type or print) First Middle Last David William PESSAGNO, Sr.			2a. DATE OF DEATH Month Day Year March 29, 1969.		2b. HOUR P. 6:25 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 18, 1916		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Marketing	12b. KIND OF BUSINESS OR INDUSTRY Pharm. Ind.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Arnold	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box 145, Rt. 2
14. FATHER'S NAME First Middle Last late David L. Pessagno		15. MOTHER'S MAIDEN NAME First Middle Last Barbara			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 212677078		17. INFORMANT Kathryn Pessagno-Alme	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (b) old Thrombo-phlebitis, L. leg DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 15 mos. ago
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/26/1969, to 3/29/1969, that (I) (we) last saw the deceased alive on 3/29/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Maurice Klawns MD				22c. DATE SIGNED 3/31/69	
22d. PHYSICIAN'S NAME (Type) M.F. KLAWAYS, MD				22e. ADDRESS 31 SOUTHGATE AV. ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/7/69	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		23d. LOCATION (City or Town) (County) (State) Annapolis AA Ind.
24. FUNERAL DIRECTOR Robert S. Lomanus, Severna Park, Md.			25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

03354

STATE OF TEXAS

03354

David William Smith
born May 1, 1911
at Fort Worth, Texas
and married to
Mary Jane Smith
born May 1, 1911
at Fort Worth, Texas

David William Smith
born May 1, 1911
at Fort Worth, Texas
and married to
Mary Jane Smith
born May 1, 1911
at Fort Worth, Texas

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1

03355

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03350

1. DECEASED-NAME (Type or print) <i>James</i> First Middle Last <i>Queen</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>2</i> Year <i>1969</i>		2b. HOUR <i>10 25</i> M
3. SEX <i>Male</i>	4. RACE <i>Col</i>	5. DATE OF BIRTH <i>9-25-18 99</i>		6. AGE (In years) <i>69</i>	7. IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>C.A.</i>		
10. CITY OR TOWN OF DEATH <i>millersville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>K. Hollwood Nursery</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>MD</i>		13b. COUNTY <i>CC</i>	13c. CITY OR TOWN <i>Damascus</i>	13d. STREET AND NUMBER <i>R. 3 Box 548</i>	
14. FATHER'S NAME <i>Louis</i> First Middle Last		15. MOTHER'S MAIDEN NAME <i>Anna Hall</i> First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>218-094204</i>		17. INFORMANT <i>Andrew Queen Balts, MD</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AS. C.U.I.D.</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF <i>Aggravated by</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchopulmonary Disease - yes!</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Brainoplegia secondary to tuberculosis / spine & lung</i>					
19a. DATE OF OPERATION <i>Dec 8</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>TBC. Spine</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>69</i> , to <i>Mar 2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Mar 2</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ray W Allen MD</i>				22c. DATE SIGNED <i>3/3/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Faye W Allen MD</i>				22e. ADDRESS <i>62 Cathedral St.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-7-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wilson Memorial</i>	
23d. LOCATION (City or Town) (County) (State) <i>Damascus MD</i>		23e. REC'D BY REGISTRAR <i>William Bease</i>		23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03322

MINISTRY OF WATER

03322



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 14
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		20. DATE OF DEATH	
Walter						QUEEN		March 15 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
Male		Negro		Feb. 12, 1912		57 YRS.		9:05 M	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Annapolis		Anne Arundel Gen. Hospital							
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				39 Pinkney St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Walter Queen Sr.		Hennetta Thomas							
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				Thomas Thomas		Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
190. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		200. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
210. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Richard N. Peeler						3/17/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Richard N. Peeler, M.D.		121 Cathedral St., Annapolis, Md.							
230. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-21-1969		Baewer Hill		Annapolis Md.			
24. FUNERAL DIRECTOR		ADDRESS		250. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William Reese		Annapolis, Md.		MAR 19 1969		Charles Judge			

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STANDARD OF WEIGHTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03357

03352

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR	
MARY				QUINCE	Month Day Year 3 25 69		11:35 A M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	NEGRO		6-5-08		60 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND	U.S.A				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE		N.A. CONVALESCENT CTR.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
4		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		419 N. LOUDON AVE.		
First Middle Lost		First Middle Lost						
Emmett Parker		Julius Akins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war/ dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		212-14-9829		Helen Wilson		Baltimore		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Left ventricular failure								
227.2 DUE TO, OR AS A CONSEQUENCE OF								
(b) Hypoglycemia, Subdural, Chronic, Ruptured								
DUE TO, OR AS A CONSEQUENCE OF								
(c) Generalized arteriosclerosis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2/24/69		Hypoglycemia, Subdural		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/21/69, 1969, to 3/25/69, 1969, that (I) (we) last saw the deceased alive on 3/25/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		22c. DATE SIGNED		
MAX C FRANK		MD		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		3/25/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
		425 SE Baltimore Hwy						
		Glen Burnie MD 21061						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3-29-69		Mt Auburn Ctr		Baltimore Md		
24. FUNERAL DIRECTOR		ADDRESS		25d. REC'D BY REGISTRAR		25e. REGISTRAR'S SIGNATURE		
Elior O. Wilson		2197 -		MAR 26 1969		Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03358					03353				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>Ervin C. Raber</u>					2a. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>69</u>			2b. HOUR <u>1:15</u> PM	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>18 July 1894</u>		6. AGE (In years last birthday) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Ohio</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Anne Arundel County</u> Md.			
10. CITY OR TOWN OF DEATH <u>Millersville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Knollwood Nursing H.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <u>Mechanic</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Anne Arundel</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>Luce Dr. Anna., Md.</u>	
14. FATHER'S NAME First Middle Last <u>John Raber</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Ida Raber</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>unk</u>		16b. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>Mrs. Charles Helm Luce Dr. Anna. Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4339</u> IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubitus ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemiplegia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>2 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis, general and cerebral with cerebral thrombosis.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11 February, 69</u> to <u>18 March, 19 69</u> , that (I) (we) lost saw the deceased alive on <u>15 March</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death.									
22b. SIGNATURE <u>Charles W. Kinzer</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 18, 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>				22e. ADDRESS <u>16 Murray Avenue, Annapolis, Md. 21401</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar 12 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Uniontown, Ohio</u>			
24. FUNERAL DIRECTOR <u>Beall Funeral Home</u>				ADDRESS <u>1212 West St. Anna Md</u>		25a. REC'D BY REGISTRAR <u>MAR 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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REMARKS OF DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03359									
1. DECEASED-NAME (Type or print)		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Annie		Elizabeth		Ravert		Month 3 Day 9 Year 69		7:20PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Sept. 16, 1875		93 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Pa.		U.S.A.				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Mihersville		Knollwood Nursing		HOME		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13a. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.		H.A.Co.		Mihersville				Mihersville Rt. #3	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
George		W.		Both		Emmalie		Wright	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				DRENE R. DOBBIUS Rt #3		Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia--4 days</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Inanition, progressive 2 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinomatosis origin & type unknown</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral thrombosis, left hemiplegia (old)</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 20</u> , 19 <u>66</u> , to <u>Mar. 9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		Charles W. Kinzer		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								10 MARCH 69	
22d. PHYSICIAN'S NAME (Type)		Charles W. Kinzer, M. D.		22e. ADDRESS		16 Murray Ave., Annapolis, Md. 21401			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		3-12-69		GREENWOOD CENT.		Annetown		Pa.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REGD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Lybrowsky		Annapolis, Md.		MAR 12 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03360					03355				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			P. M.	
Evelyn Irene RAWLINGS					March 17 1969			5:35	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		March 17, 1969		— YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		U.S.				Anne Arundel		Annapolis	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN	
Anne Arundel Gen. Hospital		Newborn				Maryland Anne Arundel		Arnold	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt-2, Box 264A,		David Allan Rawlings		Evelyn Faye Saboury		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Newborn		Hospital records				PART 1. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) IMMATUREITY		WT 116 502				DUE TO, OR AS A CONSEQUENCE OF			
777X						DUE TO, OR AS A CONSEQUENCE OF			
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		21g. LOCATION		21h. LOCATION		21i. LOCATION		21j. LOCATION	
22a. I certify that (I) (the hospital) attended the deceased from 17 March 1969, to 17 March 1969, that (I) (we) last saw the deceased alive on 17 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Sherman S. Robinson M.D.		22c. DATE SIGNED 3-18-69		22d. PHYSICIAN'S NAME (Type) Sherman S. Robinson, M.D.		22e. ADDRESS Hahn Prof Bldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/21/69		23c. NAME OF CEMETERY OR CREMATORY South National		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR	
23f. FUNERAL DIRECTOR Robert S. Banana		23g. ADDRESS Severna Park		23h. DATE MAR 24 1969		23i. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>10</div> <div>03361</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>03356</div>												
Item 2a Film 411 4/2/69 kk												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR			
First Middle Last Walter J. Robbins						Month Day Year March 21 20 1969			9 10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male		cauc.		June 13, 1926			42 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		USA					Anne Arundel Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis				Anne Arundel General				Heavy equip operator			construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland				Anne Arundel		Gambrills		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 41A		
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last						
Walter M. Robbins						Theresa King						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
yes				WW II		Mrs. Betty S. Robbins - same as #13 above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										2 hrs.		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery sclerosis</u>										4 mos.		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				19 P.M.								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 1969, to <u>3/20</u> , 1969, that (I) (we) lost the deceased alive on <u>3/20</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<i>[Signature]</i>										3/22/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County) (State)		
Burial		Mar. 24, 1969		Baltimore National Cem.				Baltimore		Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Beverly E. Hopping						MAR 24 1969		<i>[Signature]</i>				
HOPPING FUNERAL HOME - Annapolis, Md.												

03331

03334

U. S. DEPARTMENT OF AGRICULTURE

Name		Address	
John D. Smith		123 Main St.	
City		State	
New York		New York	
Occupation		Business	
Farmer		Farmer	
Age		Sex	
45		Male	
Marital Status		Education	
Married		High School	
Children		Religion	
2		Protestant	
Income		Assets	
\$10,000		\$5,000	
Liabilities		References	
\$2,000		John Doe, Farmer	
Character of Farm		Date of Report	
100 Acres		Jan 1, 1934	
Crops		Remarks	
Wheat, Corn		Good crop	
Livestock		Horses, Cows	
Other		Fruit, Poultry	
Total Value		Remarks	
\$15,000		Good farm	

03362

CERTIFICATE OF DEATH

03357

1. DECEASED-NAME (Type or print) First Middle Last Claudia Elizabeth Rogers			2a. DATE OF DEATH Month Day Year March 29, 1969		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 6, 1890		6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Manor Nurs- Housewife		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel-Anna.	13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Edward Hartege		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no	
16b. SOCIAL SECURITY NO. 218-32-2932		17. INFORMANT Address Mrs. Katherine Smith Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS 12 YRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL THROMBOSIS - 1-14-69					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/1/66 , to 3/29/69 , that (II) (we) last saw the deceased alive on 3/21/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward S. Beck		DEGREE MD		22c. DATE SIGNED 3/29/69	
22d. PHYSICIAN'S NAME (Type) Edward S. Beck MD		22e. ADDRESS 73 Franklin St., Anna., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 1, 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park Glenburnie, Anne Arundel, Md.	
23d. LOCATION (City or Town) (County) (State) Anna., Md.		24. FUNERAL DIRECTOR Beall Funeral Home, 1212 West St. Md.		25a. REC'D BY REGISTRAR APR 3 1969	
25b. REGISTRAR'S SIGNATURE Charles Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03382

STATE OF CALIFORNIA

03382

County of Santa Clara

City and County of Santa Clara

State of California

County of Santa Clara

City and County of Santa Clara

State of California

County of Santa Clara

City and County of Santa Clara

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County of Santa Clara

City and County of Santa Clara

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County of Santa Clara

City and County of Santa Clara

State of California

County of Santa Clara

City and County of Santa Clara

State of California

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03363

03358

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Jenniffer A RUCKER</i>			2. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <i>3</i> Day <i>9</i> Year <i>1969</i>			2b. HOUR <i>4</i> M <i>PM</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>1/8/69</i>	6. AGE (In years last birthday) <i>2</i> YRS. <i>1</i> MONTHS <i>1</i> DAYS	7c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>9</i> Year <i>69</i>		2d. HOUR <i>4</i> M <i>PM</i>
7a. BIRTHPLACE (State or foreign country) <i>MD. - AAC.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i>
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.O.A. NORTH ARUNDEL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>A.A. CO.</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>John</i> Middle <i>Schneider</i> Last <i>Rucker</i>		15. MOTHER'S MAIDEN NAME First <i>Jeannette</i> Middle <i>Rucker</i> Last <i>Rucker</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Jeannette Rucker (mother)</i>		17. ADDRESS <i>Same As Fr.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>795X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>SDII</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>3/9/69</i>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county) <i>A.A. CO.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 11, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Burnie, MD. -</i>
24. FUNERAL DIRECTOR <i>E.B. Fleming</i>		ADDRESS <i>Singleton Funeral Home</i>		25a. REC'D BY REGISTRAR <i>MAR 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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A. C. N.

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E. D. Fleming
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03364					03359					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
Henry Schoener					Month 3 Day 18 Year 69		12:30a			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Caucasian		5/6/91 (1891)		77 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Balto., Md.		U.S.A.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville Md.			Crownsville State Hosp.			cooper smith		Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		422 S. Oldham St. # 21224.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Maxmillian Schoener			unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			215-09-4566		Crownsville State Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cerbral haemorrhage</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Chronic brain syndrome due to arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Possible pneumonia (Hypostatic)</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>69</u> , to <u>3/18</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Charles R. Venter, M.D.</u>					22c. DATE SIGNED <u>3/18/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Charles R. Venter, M. D.</u>					22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-21-69		Sacred Heart Cemetery		4701 German Hill Rd., Ba. Co., Md.				
24. FUNERAL DIRECTOR <u>Charles S. Feiler</u>		6224 Eastern Ave. Balto., 21224, Md.		25a. REC'D BY REGISTRAR <u>MAR 24 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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STATE OF TEXAS

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U.S.A.

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Providence State Hosp.

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Providence State Hosp.

Providence State Hosp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03365		CERTIFICATE OF DEATH						03360			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
MAMTE			B. SCHUMANN			3 12 69			2:30p M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
FEMALE		WHITE		OCT. 15, 1880			88 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
BALTIMORE, MD.		U.S.A.					ANN ARUNDEL				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
LINTHICUM			220 HOMEWOOD RD.			HOUSEWIFE			HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ANN ARUNDEL		LINTHICUM				220 HOMEWOOD RD.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
THOMAS MAHAN			MARY LUTZ								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
NO			215-07-94710		CARRIE KING 220 HOMEWOOD RD. LINTHICUM, MD?						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebitis Rt. leg.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Wheeler</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs 1 week 2 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Large bed sore on back</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/4</u> , 19 <u>64</u> to <u>3/15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Chas. L. Ball</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/13/69</u>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS <u>2030 Maple Rd - Linticum Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		3/15/69		LOUDEN PARK CEMETERY		BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR <u>McCully</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>				

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101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03366		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03361	
ESTELLE DRISCOLL SCHAFFER							
1. DECEASED-NAME (Type or print) <i>Estelle</i>		First <i>F</i> Middle		Last <i>SCHAFFER</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1969</i>	
3. SEX <i>F</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>11/1/1895</i>		6. AGE (In years lost birthday) <i>73</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i>	
10. CITY OR TOWN OF DEATH <i>Crownsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Crownsville State Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Brooklyn Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>James</i> Middle <i>DRISCOLL</i> Last		15. MOTHER'S MAIDEN NAME First <i>WEINKAMP</i> Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-03-9162</i>	
17. INFORMANT <i>Medical Records, Crownsville State Hospital</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>7312</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Abscess of Oesophagus Bursa</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>17 days</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>17 days</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pneumonitis</i> <i>Arteriosclerotic Cardiovascular Disease with Chronic Brain Syndrome</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/30/63</i> , 19__, to <i>3/28/69</i> , 1969, that (I) (we) last saw the deceased alive on <i>3/28/69</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Walter Henry Mapp</i>		22c. DATE SIGNED <i>3/29/69</i>		22d. PHYSICIAN'S NAME (Type) <i>Walter Henry Mapp</i>		22e. ADDRESS <i>Crownsville State Hospital, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-1-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HOLY REDEEMER</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>GEORGE J. GONCE</i>		ADDRESS <i>4001 RITCHIE HWY. 21225</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

20550

Page 189A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03367

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03362

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LOUISE CAMPBELL SHARP			2a. DATE OF DEATH Month MARCH Day 20 Year 1969			2b. HOUR 4:00 PM				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 4 December 1884		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 197 HANOVER STREET	
14. FATHER'S NAME First Middle Last LEVIN HICKS CAMPBELL			15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA HOLLYDAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 219 32 2699		17. INFORMANT Address OUT PATIENT RECORD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1560 METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SECONDARY TO CARCINOMA OF THE COLON DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE GALLBLADDER									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 22 January, 1969 , to 20 March, 1969 , that (I) (we) lost saw the deceased alive on 20 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael F. Fornes						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 March 1969		
22d. PHYSICIAN'S NAME (Type) M. F. FORNES LCDR MC USN						22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.D. MD.			
24. FUNERAL DIRECTOR John M. Lyons Sons Annapolis, Md.						25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

50680

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03368		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03363					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M			
Joseph Chester Sheehan						March 23 1969		P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN		
Male		White		6-17-1915		53 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
		USA				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Severna Park		Old County Rd. Box 18		Physician		Obstetrics					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Anne Arundel		Severna Pk.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Old County Rd Box 18			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John				MARR	SHEEHAN	HELEN				CHESTER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name of service (If yes give year and date of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			WW II			BERUARDINE SHEEHAN			#13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prof. Ar. Coronary Occlusion 4109 DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 15 yr. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DOA 15 yr.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1954, to 3-23-69, that (I) (we) last saw the deceased alive on 3-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Frank M. Shipley M.D.		F.M. SHIPLEY				Annapolis, Md		3-28-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				22f. REGISTRAR'S SIGNATURE					
F.M. SHIPLEY		Annapolis, Md				Charles Judge					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR			23f. REGISTRAR'S SIGNATURE
BURIAL		3-26-69		MEADOWRIDGE		ELKRIDGE HOWARD MD.		MAR 26 1969			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Lytle & Son Annapolis, Md						MAR 26 1969					

03368

RECEIVED

RECEIVED

62

1962

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "1962" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03369										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03364																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR A																																																											
First Middle Last										Month Day Year										Hour Min																																																											
Rose Melvina SHOCKLY										March 31, 1969										6:55 M																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
Female										Negro										July 13, 1887										81 YRS.										MONTHS										DAYS										HOURS										MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
New Jersey										U. S. A																				Anne Arundel County																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Annapolis										Anne Arundel General										Retired Teacher										Public School																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
Maryland										Anne Arundel										Annapolis										YES <input type="checkbox"/> NO <input type="checkbox"/>										843 Spa Road																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																																																	
David Scudder										Rose Sears																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
										213 72-2264										Mr David Shockly										201 Preston St Baltimore Md 21217																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										4124 Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) A.C.U.D										1-3 min																																																											
										(c)										year.																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Oct 1968, to 3-31-69, that (I) (we) lost saw the deceased alive on 3-30-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																																	
22d. PHYSICIAN'S NAME (Type)										F M SHEPLEY										22e. ADDRESS										Annapolis, Md																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										April 3, 1969										Arbutus Cemetery										Baltimore, Md																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Elmer E. Bullock										712-14 8 North Ave Baltimore Md 21202										APR 3 1969										Charles Judge																																																	

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1995, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

החברות: [שם החברה] [שם החברה]

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03370

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03365

1. DECEASED-NAME (Type or print) First Middle Last Arthur Lee Shreve			2a. DATE OF DEATH Month Day Year March 12 1969			2b. HOUR 0755^A			
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 16 Jul 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH FT MEADE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Army Officer		12b. KIND OF BUSINESS OR INDUSTRY Military			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Queen Anne		13c. CITY OR TOWN Queenstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT #1 Queenstown, Md.	
14. FATHER'S NAME First Middle Last Arthur Lee Shreve			15. MOTHER'S MAIDEN NAME First Middle Last Harriet Rebecca Gale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		16b. SOCIAL SECURITY NO. 1917-1952		17. INFORMANT Julia Shreve		Address RT#1 Queenstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Kidney 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 26 FEB 19 69 , to 12 MAR 19 69 , that (I) (we) lost saw the deceased alive on 11 MAR 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE Louis A. Frederick, MD				22c. DATE SIGNED 12 MAR 69		22d. PHYSICIAN'S NAME (Type) Louis A. Frederick, MD, MC		22e. ADDRESS Kimbrough Army Hospital Ft. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-15-69		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City or Town) (County) (State) Ellicott City Howard Md.			
24. FUNERAL DIRECTOR Higinbotham-Stuck				25. REC'D BY REGISTRAR DATE MAR 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03330

03330

RECORD OF DEATH

NAME: [illegible]
BIRTH: [illegible]
DEATH: [illegible]
CAUSE: [illegible]
PLACE: [illegible]
DATE: [illegible]
TIME: [illegible]
SEX: [illegible]
AGE: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
RACE: [illegible]
ETHNICITY: [illegible]
SPOUSE: [illegible]
CHILDREN: [illegible]
PARENTS: [illegible]
SIBLINGS: [illegible]
BROTHERS: [illegible]
SISTERS: [illegible]
GRANDPARENTS: [illegible]
GRANDCHILDREN: [illegible]
Aunts: [illegible]
Uncles: [illegible]
Nephews: [illegible]
Nieces: [illegible]
Cousins: [illegible]
In-laws: [illegible]
Out-laws: [illegible]
Other relatives: [illegible]
Friends: [illegible]
Neighbors: [illegible]
Community: [illegible]
Religious community: [illegible]
Political community: [illegible]
Social community: [illegible]
Professional community: [illegible]
Academic community: [illegible]
Artistic community: [illegible]
Sports community: [illegible]
Hobby community: [illegible]
Volunteer community: [illegible]
Other community: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03371

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03366

1. DECEASED-NAME (Type or print) First Middle Last Ella Bullin SIMMONS			2a. DATE OF DEATH Month Day Year March 14, 1969			2b. HDUR A. 2:25 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 12, 1876		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel County Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 521 Horn Point Drive			
14. FATHER'S NAME First Middle Last William Wallace Bullen			15. MOTHER'S MAIDEN NAME First Middle Last LEE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (If unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT MARY A. RUSSELL CAPE ST. EMILIE ANNAPOLIS, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, Generalized 10 YEARS (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DEHYDRATION ARTERIOSCLEROTIC HEART DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from April 1, 1960, to 14 MAR 1969, that (1) (we) last saw the deceased alive on 13 MAR 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward S. Beck				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/69.			
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M. D.				22e. ADDRESS 73 Franklin Street, Annapolis, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-17-69		23c. NAME OF CEMETERY OR CREMATORY LICKREST		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.					
24. FUNERAL DIRECTOR John M. Gibson Annapolis, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03831

CERTIFICATE OF DEATH

03831

State of New York, County of Hamilton, City of Albany, March 14, 1904

That I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct copy of the original record of the death of

the person named above, as the same appears from the records of the City of Albany, New York.

Witness my hand and the seal of the City of Albany, New York, this 14th day of March, 1904.

Attest:

City Clerk of Albany, New York

Notary Public for the City of Albany, New York

My Commission Expires

at

the

day of

190

at

the

day of

190

at

the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03372

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03367

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Raymond		L.		Singleton, Sr.	March 15 1969		1:30 ^{am}		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male	White		17 October 1912		56 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
AA Co., Md.	USA				Anne Arundel		Nat'l. Plastic		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		219 Fourth Ave. S.W.		Machinist					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		AA		Glen Burnie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		219 4th Ave. S. W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Charles Elmer Singleton		Jane E. Wood		no		212-05-5106		Mrs. Agnes R. Singleton, same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1968, to 3-15-69, that (I) (we) last saw the deceased alive on 3-15-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Frank Groll, M.D.		18 March 1969		11 E. Eager Street, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REGISTRAR'S SIGNATURE	
Burial		18 March 69		Glen Haven Memorial Park		Glen Burnie, AA, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
Kirkley Funeral Home, Glen Burnie, Md.				MAR 20 1969					

5788

11. *Chrysomelidae*

Figure 2

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Lyndal S. Smith

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10. *Chlorophyll*

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

442 David C. Reardon

7. Выводы и рекомендации

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"Bible Study - Hebrew Bible" . . .

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First A		Middle CONSTANT		Last J. SKOLOUT		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3/28/ 1969	2b. HOUR M M
3. SEX male	4. RACE white	5. DATE OF BIRTH OCT 10 1919	6. AGE (In years last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month April Day 11 Year 1969	2d. HOUR 7:45 P.M.	
7a. BIRTHPLACE (State or foreign country) KANSAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SEVERN RIVER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER FRIARY St. Conrads Treary		
14. FATHER'S NAME First JOHN			Middle S		Last SKOLOUT		15. MOTHER'S MAIDEN NAME First MARY R. Middle CHEBORAD Last CHLEBORAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT FR BRENDAN MALLOY # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumably Drowned 984X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. Na. _____		City or Town _____		County _____	State _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 4/12/69				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/15/1969		23c. NAME OF CEMETERY OR CREMATORY ST AUGUSTINES CEM		23d. LOCATION (City or Town) MILLVALE PA.		(County) _____ (State) _____		
24. FUNERAL DIRECTOR JOHN M. TAYLOR - SONS ANNAPOLIS				ADDRESS ANNAPOLIS		25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

08333

FOR FILE
HEALTH DEPT



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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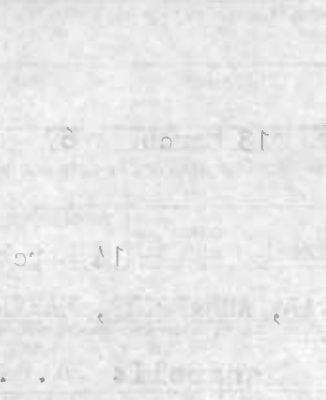
03374		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03368		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1969</u>		2b. HOUR <u>5:05</u> AM
WAVERLY			EMMETTE		SMITH			
3. SEX Male		4. RACE Negroid		5. DATE OF BIRTH 22 January 1901		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 76 Clay Street
14. FATHER'S NAME First Middle Last ALVIN NMN SMITH			15. MOTHER'S MAIDEN NAME First Middle Last GERTRUDE NMN KING					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes No (or unknown) Yes		16b. SOCIAL SECURITY NO. 1917-1944		17. INFORMANT JAMES T. SMITH		Address 76 Clay Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDOPATHY</u> <u>425X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>28 February, 1969</u> , to <u>13 March, 1969</u> , that (I) (we) last saw the deceased alive on <u>13 March</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A. C. J. Brickel</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 14 March 1969		
22d. PHYSICIAN'S NAME (Type) A. C. J. BRICKEL LT MC USNR				22e. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-17-1969		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md		
24. FUNERAL DIRECTOR C.E. Hikes, 111 30 Washington, Anna. Md				25a. REC'D BY REGISTRAR MAR 18 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

(1)



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

[illegible text follows]

03375

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03369

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
ESTELLA			P	SMOBT	Month 3 Day 6 Year 69					A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
F	N	5-7-00		68 YRS.	MONTHS DAYS		HOURS MIN.		Month 3 Day 6 Year 69		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
A.A. Co. Md.		U.S.A.				Anne Arundel Co. Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
glen Burnie				MDA-NORTH. ARUND. HOSP.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD				A.A. Co.		PRAEDENR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Elizabeth Rd Box 124 R.F.D. 20	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JOS. PINKET				ELLA DOCKINS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO						J.D. PLUM					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>Generalized</u> <u>6 N B</u> <u>Stroke</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Chronic</u> <u>Renal</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				3-6-69			
F. Low				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				A.A. Co.			
ADDRESS				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				3/10/69		Mt Zion Church		Magdaly Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. J.				MAR 10 1969		Charles Judge	

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MAY 11 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03376

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03370

1. DECEASED-NAME (Type or print) Edith Dill Spinney			2a. DATE OF DEATH Mar. 3 Month Day 1969		2b. HOUR 235 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 23, 1889		6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANN ARUNDEL Md.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Manner Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 407 Marie Ave.	
14. FATHER'S NAME First Middle Last George Dill		15. MOTHER'S MAIDEN NAME First Middle Last Annie Longfellow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT 407 Marie Ave. Barbara Tennant Glen Burnie		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 26, 1968 , to Mar 3, 1969 , that (I) (we) lost saw the deceased alive on Feb 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ray M Smith		DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 3, 1969	
22d. PHYSICIAN'S NAME (Type) RAY M SMITH MD		22e. ADDRESS SEVERNA PARK Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-6-69	23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) / (County) (State) Greensboro, Caroline, Md.
24. FUNERAL DIRECTOR F. E. Boudreau		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR MAR 6 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

07880

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03377

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03371

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
RAYMOND				SROCK	MARCH Month 5 Day 1969 Year		3:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		30 AUG 1913		55 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Penna.		USA				Anne Arundel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Ft Geo G. Meade		U.S. Kimbrough Army Hosp		Serviceman Ret'd		U.S. Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
STATE Maryland		Anne Arundel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt #3, Box 16A			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Jacob				Srock	Cathryn				Johnson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		1941-1961		Violet Srock (wife)		same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerstric Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 5 Mar, 1969, to 5 Mar, 1969, that (X) (we) last saw the deceased alive on 5 Mar 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) JOHN J. ROTHSCILD, CPT, MC					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
US KIMBROUGH ARMY HOSP, FT MEADE, MD		US KIMBROUGH ARMY HOSP, FT MEADE, MD		US KIMBROUGH ARMY HOSP, FT MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		March 19 1969		Arlington NATIONAL		FT MEYER, VA.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. ADDRESS		24c. ADDRESS		24d. ADDRESS	
Singleton Funeral Home		Glen Burnie		Md		DATE MAR 10 1969		J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03378

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03372

1. DECEASED-NAME (Type or print) <i>James Wesley Suit</i>			2a. DATE OF DEATH Month <i>Mar</i> Day <i>18</i> Year <i>69</i>			2b. HOUR <i>709</i> M	
3. SEX <i>male</i>		4. RACE <i>cauc.</i>		5. DATE OF BIRTH <i>Oct. 23, 1884</i>		6. AGE (In years last birthday) <i>84</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA Anne Arundel General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>farmer ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>tobacco</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Davidsonville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>--</i>		14. FATHER'S NAME First <i>John</i> Middle <i>W.</i> Last <i>Suit</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>E.</i> Last <i>Walker</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>218-36-5681</i>		17. INFORMANT Address <i>Elizabeth M. Suit - Davidsonville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs</i> <i>20 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 18, 1969</i> to <i>Mar 18, 1969</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>3/18/69</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (did) (<i>did not</i>) view the body after death.							
22b. SIGNATURE <i>S. Borssuck MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/19/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>S. Borssuck MD</i>		22e. ADDRESS <i>Annapolis Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/21/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Davidsonville Methodist</i>		23d. LOCATION (City or Town) (County) (State) <i>Davidsonville A.A. Md.</i>	
24. FUNERAL DIRECTOR <i>Beverley E. Hopping</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
HOPPING FUNERAL HOME - Annapolis, Md.				DATE <i>MAR 24 1969</i>			

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VR 11-1-69
45M - 109

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
03379 CERTIFICATE OF DEATH 03373

1. DECEASED-NAME (Type or print) <u>SUNDERLAND, JAMES C</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>69</u>		2b. HOUR <u>0945</u> M
3. SEX <u>MALE</u>	4. RACE <u>CAU</u>	5. DATE OF BIRTH <u>MAY 14 1921</u>		6. AGE (In years last birthday) <u>47</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>ANNE ARUNDEL</u> Md.		
10. CITY OR TOWN OF DEATH <u>FT. GEO. G. MEADE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>KIMBROUGH ARMY HOS</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>SERGEANT</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> <u>ADWARD</u>		13b. CITY OR TOWN <u>ELLICOTT</u>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>	
14. FATHER'S NAME First Middle Last <u>JAMES EDGAR SUNDERLAND</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>VELLEY ESTELLE TUCKER</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>0142-1062-215-12-541</u>		17. INFORMANT Address <u>Anna Margaret Sunderland, 3114 Mayfield Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>immediate</u> <u>7 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>15 MAR 1969</u> , to <u>15 MAR 1969</u> , that (I) (was) last saw the deceased alive on <u>15 MAR 1969</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Olav H. Stern MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>15 MAR 69</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>KIMBROUGH ARMY HOS FT. MEADE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 18, 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Harry H. Nitzke, 4112 Columbia Pk, Ellicott City, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

08379

08379

Name of deceased		James C. [illegible]	
Date of birth		May 10, 1901	
Place of birth		New York City	
Cause of death		Heart disease	
Date of death		May 10, 1901	
Place of death		New York City	
Signature of physician		[illegible]	
Signature of registrar		[illegible]	
Date of registration		May 17, 1901	
Place of registration		New York City	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1515
30M REV. 7-52

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03380 CERTIFICATE OF DEATH 03374									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
KAYTE			NANNIE SYKES			Month 3 Day 15 Year 69			11:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
FEMALE		WHITE		10-11-16 15		53 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE			NORTH ARUNDEL			Seamstress			Hooper Mill
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND						BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
(Late) Thomas (Dye)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
			227-40-8694			Curtis Sykes, Box 20-A, Stoney Run, Hanover, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>5 yr</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>3/15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Chas. L. Ball</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/16/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>DR CHARLES BALL</u>						22e. ADDRESS <u>2039 Maple Rd. Centreville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 19, 1969		Crestlawn Cemetery		Howard County, Md.			
24. FUNERAL DIRECTOR <u>Witzke-Hollins & Gilmore Sts., Balto.</u>						25a. REC'D BY REGISTRAR <u>MAR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03380

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STATE

THOMAS

NOTE

10-11-59

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THOMAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

03381				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03375							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
James				A.		Szamski		3 27 69				6:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		8-1-1886				82 YRS.				MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				Md.			
Maryland		U. S. A.		WIDOWED		DIVORCED		Anne Arundel							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie		North Arundel Hospital		Retired											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		724 S. Lakewood Ave.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
PETER		SZAMSKI						JOSEPHINE		PAWLAK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address									
YES		218-38-3870		MRS. HELEN SZAMSKI		724 S. LAKEWOOD AVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												From			
IMMEDIATE CAUSE (a) Myocardial Failure															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b) Generalized arteriosclerosis		year	
DUE TO, OR AS A CONSEQUENCE OF												(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year													
		P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from 3-17-1969, to 3-27-1969, that (I) (we) last saw the deceased alive on 3-27-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE			
Hilary McNeil		3-27-19				Hilary O'Heer, M.D.						Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
BURIAL		MARCH 31 1969		Holy Rosary Cemetery		BALTIMORE				MD.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
RAYMOND L. KACZIROWSKI		2525 FLEET ST.				APR 7 1969									

1880

2004

Chrysomelid Larva

4-73-5

1877

X

2381 1 894

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03382

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03376

1. DECEASED-NAME (Type or Print) PERCY E. TAYLOR			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 13 Year 69			2b. HOUR 1:20 M PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH 6-19-1907	6. AGE (In years last birthday) 61 YRS.	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 3 Day 13 Year 1969		
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) F.A. GENERAL Hospt.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY BUILDING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY A.A.		13c. CITY OR TOWN EDGEWATER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER MD. Pt 214	
14. FATHER'S NAME First Clinton Middle Taylor Last Taylor			15. MOTHER'S MAIDEN NAME First Mattie Middle Eades Last Eades					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 1			17. INFORMANT ADDRESS VELINA H. TAYLOR #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4299 Cardiac Disease								Under
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 0 P.M. 0		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Elmer G. Linhardt M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/13/69
EXAMINER'S NAME (Type) ELMER G. LINHARDT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-16-69		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.		
24. FUNERAL DIRECTOR John M. G. [Signature]				ADDRESS ANNAPOLIS, MD.		25a. RECD BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE [Signature]

\$3650

19 6 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03383										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03377									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) <u>James Hermon Thomas</u>										2a. DATE OF DEATH <u>3-25-69</u> Month <u>3</u> Day <u>25</u> Year <u>69</u>										2b. HOUR <u>7A</u>									
3. SEX <u>M.</u>			4. RACE <u>W.</u>			5. DATE OF BIRTH <u>Feb 16, 1903</u>			6. AGE (In years last birthday) <u>66</u> YRS.			IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>			IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>														
7a. BIRTHPLACE (State or foreign country) <u>Va</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>A.A.</u>																				
10. CITY OR TOWN OF DEATH <u>Severna Park</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Richard Helms Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Supervisor</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>crd</u>																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md</u>			13b. COUNTY <u>A.A.</u>			13c. CITY OR TOWN <u>Severna Park</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <u>Pattee Highway Express</u>																	
14. FATHER'S NAME First <u></u> Middle <u></u> Last <u></u>					15. MOTHER'S MAIDEN NAME First <u></u> Middle <u></u> Last <u></u>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <u>no</u> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <u></u>					17. INFORMANT <u>Luna Edna Thomas - alone</u> Address <u></u>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>																													
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.C. V.D.</u>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senor</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u> P.M. <u></u>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u></u> , to <u>1969</u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>3-15-69</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Robert R. Hahn MD</u>										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>3-25-69</u>														
22d. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>										22e. ADDRESS <u>P.O. Box 73 Severna Park</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <u>3/28/69</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>					23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Md</u>														
24. FUNERAL DIRECTOR <u>Robert S. Bannan</u>										ADDRESS <u>Severna Park, Md</u>					25a. REC'D BY REGISTRAR <u>APR 1 1969</u>					25b. REGISTRAR'S SIGNATURE <u>W. C. ...</u>									

03383

RECORDS OF DEATH

DEPARTMENT OF HEALTH

03383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03384

CERTIFICATE OF DEATH

03378

1. DECEASED-NAME (Type or print) <i>Gertrude Thompson</i>		2a. DATE OF DEATH 3-25-69		2b. HOUR 3:00 P.M.	
3. SEX F	4. RACE W.	5. DATE OF BIRTH 3 Feb 1896	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md, Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.A.
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A.A. Gen. Hosp.		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY A.A.	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 201 Reggs Ave
14. FATHER'S NAME First Middle Last Jacob Bowling		15. MOTHER'S MAIDEN NAME First Middle Last Minnie Emerich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Albert T. Thompson - Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>C.E. V.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sen art.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1955</i> 19__, to <i>1967</i> 19__, that (I) (we) lost saw the deceased alive on <i>3-17-69</i> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert R. HAHN</i>		22c. DATE SIGNED 3-25-69		22d. PHYSICIAN'S NAME (Type) Robert R. HAHN	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/28/69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24. FUNERAL DIRECTOR <i>Robert A. Bananas</i>		25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE <i>William C. ...</i>	

43660

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03385

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03379

1. DECEASED-NAME (Type or print) NANCY E. TIER			First Middle Last			2a. DATE OF DEATH Month 3 Day 5 Year 69			2b. HOUR 3:00A		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 26 Mar 1887			6. AGE (In years lost birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE-ARRUNDEL Md.				
10. CITY OR TOWN OF DEATH FORT MEADE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KIMBROUGH ARMY HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 4016 Massachusetts Ave			14. FATHER'S NAME First JOHN Middle SEE Last AMANDA			15. MOTHER'S MAIDEN NAME First AMANDA Middle GOFF Last GOFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 402-14-8885			17. INFORMANT MARVIN E TIER			Address 4016 Mass. Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 hours Unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that 41 (this hospital) attended the deceased from 3 Mar , 19 69 , to 5 Mar , 19 69 , that 41 (we) last saw the deceased alive on 5 Mar , 19 69 , and that in (my) (am) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Colman R Sachs DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 5 Mar 69		
22d. PHYSICIAN'S NAME (Type) COLMAN R SACHS						22e. ADDRESS Kimrough Army Hospital Fort George G Meade, Maryland 20755					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE MARCH 8, 1969			23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEM.			23d. LOCATION (City or Town) (County) (State) LAWRENCE Co. Kentucky		
24. FUNERAL DIRECTOR G. TRUMAN Schwab ADDRESS BALTO MD.						25a. REC'D BY REGISTRAR DATE MAR 7 1969			25b. REGISTRAR'S SIGNATURE Charles J. J...		

03380

OFFICE OF DEATH

03380

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7
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03386		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03380	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print) <i>Charles Herbert TILMAN</i>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>23</i> Year <i>1969</i>		2b. HOUR <i>10</i> M	
3. SEX <i>M</i>		4. RACE <i>N</i>		5. DATE OF BIRTH <i>4-13-1908</i>		6. AGE (In years last birthday) <i>60</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>—</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>OYSTERMAN</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>OYSTER</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Gene</i> Middle <i>Tilman</i> Last <i>Lattie</i>		15. MOTHER'S M maiden name First <i>Brown</i> Middle <i>—</i> Last <i>—</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16b. SOCIAL SECURITY NO. <i>214-05217</i>	
17. INFORMANT <i>Pearl Wees</i>		18. ADDRESS <i>4455 Boston Heights Ave. Md.</i>		19. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>—</i>		21b. TIME OF INJURY Month, Day, Year <i>—</i> HOUR A.M. <i>—</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>No injury</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i>		21f. LOCATION Street or R.F.D. No. <i>—</i> City or Town <i>—</i> County <i>—</i> State <i>—</i>		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22b. DATE SIGNED <i>3/23/69</i>		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22d. ADDRESS (Street, city, town, or county) <i>—</i>		22e. SIGNATURE <i>Charles H. Wirth</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-27-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Marks</i>		23d. LOCATION (City or Town) <i>Mayo</i> (County) <i>md</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>		24a. ADDRESS <i>Annapolis Md</i>		25a. REC'D BY REGISTRAR <i>MAR 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03330

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

03330

FOR THE
UNITED STATES

[Faint, mostly illegible handwritten text and markings covering the main body of the document. Some words like "UNITED STATES" and "DEPARTMENT OF AGRICULTURE" are faintly visible.]

MAR 24 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03387

CERTIFICATE OF DEATH

03381

1. DECEASED NAME (Type or print) ODESSA V. TYSON			2a. DATE OF DEATH Month March Day 7 Year 69			2b. HOUR 7:00 ^P	
3. SEX Female		4. RACE Neg		5. DATE OF BIRTH 10 Jan 1940		6. AGE (In years last birthday) 29 YRS.	
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH DOA - Ft. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA - Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ft. Meade		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8008 A Burk Ct. Ft. Meade		14. FATHER'S NAME First Middle Last Otis Barnes		15. MOTHER'S MAIDEN NAME First Middle Last Pauline M. Barksdale			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (Illegible)		17. INFORMANT Wince L. Tyson (husband) 8008 A Burk Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4389 IMMEDIATE CAUSE (a) ACUTE CEREBRAL EDEMA, MARKED DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from DOA 7 Mar, 1969 , to 7 Mar, 1969 , that (I) (we) last saw the deceased alive on 7 Mar, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan G. Stern				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 8 Mar 69	
22d. PHYSICIAN'S NAME (Type) ALAN G. STERN, Cpt, MC				22e. ADDRESS Kimbrough Army Hospital Ft. Meade, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 13 '69		23c. NAME OF CEMETERY OR CREMATORY Fort Riley		23d. LOCATION (City or Town) (County) (State) Fort Riley Kansas	
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry Witzke				ADDRESS Ellicott City Maryland		25a. REC'D BY REGISTRAR MAR 10 1969	
				25b. REGISTRAR'S SIGNATURE Johnas Judge			

MEDICAL CERTIFICATION

08880

CH. 10. -

08880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-66

03388										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03382																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										A																													
JAMES J VACEK										3/										10 69 6:05M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
Male										White										3/13/1914										54 YRS.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.									
Maryland										U. S. A.																				A. A.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
Glen Burnie, Md.										North Arundel										Mechanic										Auto																			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER									
Md.										A. A.										Glen Burnie										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										126 Main Avenue, SW									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
First Middle Last										First Middle Last																																							
Valac J. Vacek (Dec)										Anna										Brosh (Dec)																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																			
No.										217-09-6850										Chart North Arundel										301 Hospital 1																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										Coronary thrombosis A. S. C. V. D.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from June 16, 1962, to March 10, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										22c. DATE SIGNED																																							
Robert Dabolins MD DEGREE										ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										5-10-69																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																							
Robert Dabolins										400 Crain Hwy, NW Glen Burnie																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										3/13/1969										Glen Gaven Cemetery										Glen Burnie, Md.																			
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Raymond C. Fink										Glen Burnie, Md.										DATE MAR 12 1969 Charles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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03389

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03383

1. DECEASED-NAME (Type or print) Philip - Vitale			2a. DATE OF DEATH Month March Day 17 Year 1969			2b. HOUR 7:10 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-27-13		6. AGE (In years lost birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dispatcher		12b. KIND OF BUSINESS OR OCCUPATION Asphalt, Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 505 Stanhome Rd.		14. FATHER'S NAME First Philp Middle Vitale Last Vitale		15. MOTHER'S MAIDEN NAME First Joeshine Middle (unknown) Last (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Madeline S. Vitale - Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Disease DUE TO, OR AS A CONSEQUENCE OF Chronic Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Renal Disease DUE TO, OR AS A CONSEQUENCE OF Chronic Renal Disease (c) Chronic Renal Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months 710 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1960 , to 7-17-1969 , that (I) (we) last saw the deceased alive on 7-17-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hilary O'Herlihy				DEGREE MD.		22c. DATE SIGNED 7-17-69	
22d. PHYSICIAN'S NAME (Type) Dr. Hilary O'Herlihy, MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/21/69		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.				25a. REC'D BY REGISTRAR MAH 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03338

EXHIBIT OF DEATH

DIVISION OF VITAL RECORDS, NEW YORK STATE DEPARTMENT OF HEALTH

1933

Johnnie (Mother)

Johnnie

Johnnie

Johnnie - 1933

Johnnie

Johnnie

1933

Johnnie

Johnnie

Johnnie

Johnnie

Johnnie

Johnnie

Johnnie

Johnnie

Johnnie

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Johnnie

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03390					03384				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First		Middle		Last		Month		Day	
JOHN		WALCH				March		21	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
male		cauc.		Oct. 24, 1899		69		MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Germany		USA				Anne Arundel		Iron Works	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		DOA Anne Arundel General		Mechanic					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Gambrills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 302	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO.		17. INFORMANT	
John		Julia				213-10-0309		Juliana Ammon - Gambrills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sclerotic Hypertensive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
Atherosclerosis, Myocardial Infarction									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	
1960, to Jan 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		John Walch		3/21/69		Rebus Gounberg		1119 Odenton Rd. Odenton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		3/22/69		Our Lady of Sorrows		Owensville		A.A. Md.	
24. FUNERAL HOME		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
HOPPING FUNERAL HOME - Annapolis, Md.		MAR 24 1969		Charles Judge					

03330

acute myocardial infarction
sclerotic hypovascular

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03391

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03385

1. DECEASED-NAME (Type or print) First Middle Last RAYMOND. SEARPHINE WEZIK.			2a. DATE OF DEATH Month 3 Day 10 Year 69		2b. HOUR 10.20 P.M.
3. SEX MALE	4. RACE WHITE		5. DATE OF BIRTH 10-09-10		6. AGE (In years last birthday) 58 YRS.
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH ANNE-ARUNDEL		Md.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE-ARUNDEL GEN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Grocery Store	
12b. KIND OF BUSINESS OR INDUSTRY Owner					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Croftsville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 511			
14. FATHER'S NAME First Middle Last Joseph Wezik			15. MOTHER'S MAIDEN NAME First Middle Last Agnes Rozniarek		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Betty Wezik Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. Hemorrhage. 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Same. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION 2-22-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rupt. AORTIC ANEURYSM.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bolivar Herdoiza M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Bolivar Herdizo		22e. ADDRESS Anne Arundel General Hosp. Annapolis		22c. DATE SIGNED 3-10-69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-13-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR George J. Gonce		ADDRESS Funeral Home 4001 Ritchie Hgway		25a. REC'D BY REGISTRAR MAR 17 1969	
25b. REGISTRAR'S SIGNATURE [Signature]					

038301

2-20-47 Rpt. Arctic Anemometer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03392

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03386

1. DECEASED-NAME (Type or print) First Middle Last <i>Mary Frances Windsor</i>			2a. DATE OF DEATH Month Day Year <i>March 3 1969</i>		2b. HOUR 12:30 AM
3. SEX <i>Female</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>9-14-1920</i>		6. AGE (In years last birthday) <i>48</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Anne Arundel</i> Md.		
10. CITY OR TOWN OF DEATH <i>Lothian</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A. A. Lothian</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Lothian</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last <i>Charles Easton</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Martha Bruce</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Horace Windsor</i> Address <i>Lothian Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Willard F. Smith</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>3/4/69</i>
22d. PHYSICIAN'S NAME (Type) <i>Willard F. Smith MD</i>		22e. ADDRESS <i>Shady Side, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3-6-1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Apostolic</i>		23d. LOCATION (City or Town) (County) (State) <i>Ti. B. Md.</i>	
24. FUNERAL DIRECTOR <i>William Beese Jr.</i>		ADDRESS <i>Anne Arundel</i>		25. RECEIVED BY REGISTRAR DATE <i>5 1969</i>	26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

03333

03333

Handwritten notes and diagrams, including a circular diagram with internal lines and various scribbles.

Handwritten notes at the bottom of the page, including the word "Project" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03393									
CERTIFICATE OF DEATH									
03387									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Martin			C Yockel			3 12 69			8:35p
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
Male		White		12-16-94			76 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Maryland			U.S.A.						Anne Arundel
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie, Md.			North Arundel			Sales Mgr.			Bakery
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			ANNE ARUNDEL			Baltimore		13e. STREET AND NUMBER	
								5204 Ritchie Hwy 21225	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Alexander Yockel			Ella Humpert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			215-07-3546			Mrs. Mildred F. Yockel			Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardium Cordis Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Spontaneous atherosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>62</u> , to <u>3/12</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Benjamin S. Finsen</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/12/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS <u>7308 FURNACE BRANCH RD, Glen Burnie, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		3-17-69		Cedar Hill			Anne Arundel Co., Md.		
24. FUNERAL DIRECTOR George J. Gonce					ADDRESS 4001 Ritchie Hwy.		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE <u>Michaela Judge</u>

88383

STATE OF TEXAS

1950

IN SENATE, FEBRUARY 1, 1950.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

RECEIVED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

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RECEIVED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03394

03388

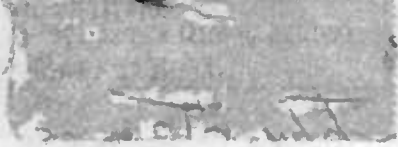
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) John James ZEMAITIS		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 17 Year 1969		2b. HOUR P
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-14-06	6. AGE (In years last birthday) 62 YRS.	7c. DATE PRONOUNCED DEAD May 3 Month Day Year 1969
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH Anne Arundel Co.		10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Co. Gen'l. Clerk
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Gen'l. Clerk		12b. KIND OF BUSINESS OR INDUSTRY Real way		13a. STREET AND NUMBER 215 Gibson Road
13b. COUNTY ADCO		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME Anthony Zemaitis		15. MOTHER'S MAIDEN NAME Mary		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No
16b. SOCIAL SECURITY NO. 4124		17. INFORMANT Fern G. Zemaitis		ADDRESS 259 Gibson Rd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-17-69
EXAMINER'S NAME (Type) E. Linhardt		ADDRESS (Street, city, town, or county) ADCO		
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE March 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Glen Haven
23d. LOCATION (City or Town) Glen Burnie		23e. (County) ADCO		23f. (State) MD
24. FUNERAL DIRECTOR Charles W. Wynn		ADDRESS 1400 S. Charles St		25a. REC'D BY REGISTRAR MAR 19 1969
				25b. REGISTRAR'S SIGNATURE Charles Wynn



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